

REVIEWING THE ACCURACY OF MEDICAID AND EXCHANGE ELIGIBILITY DETERMINATIONS

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FOURTEENTH CONGRESS FIRST SESSION

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FRIDAY, OCTOBER 23, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:00 a.m., in room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Blackburn, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Collins, Green, Engel, Capps, Butterfield, Sarbanes, Matsui, Luján, Schrader, Kennedy, Cárdenas, and Pallone (ex officio).

Staff Present: Clay Alspach, Counsel, Health; Rebecca Card, Staff Assistant; Graham Pittman, Legislative Clerk; Michelle Rosenberg, GAO Detailee, Health; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Josh Trent, Professional Staff Member, Health; Christine Brennan, Minority Press Secretary; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Chief Oversight Counsel; Rachel Pryor, Minority Health Policy Advisor; and Samantha Satchell, Minority Policy Analyst.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The hearing will come to order. The chair will recognize himself for an opening statement.

Today's hearing will review the accuracy of eligibility and financing determinations made by the Center of Medicare and Medicaid Services, CMS. Both CMS's eligibility determinations for Medicaid and subsidies in the Federal and state health insurance exchanges, and CMS's oversight of Federal matching funds in the Medicaid program.

As we know, the ACA created taxpayer-funded subsidies for healthcare coverage for certain individuals, and also required establishment of state-based or federally-facilitated exchanges. As of June of this year, more than 9 million individuals have had effectuated exchange coverage, including more than 8 million individuals who are receiving Federal subsidies. The ACA also expanded

Medicaid to cover childless adults in what was the largest expansion of Medicaid since the program's creation in 1965.

Since October of 2013, more than 13 million individuals have been enrolled in Medicaid and CHIP, including at least 7.5 million newly eligible individuals enrolled in Medicaid. Whether or not CMS is making accurate determinations for the exchanges in Medicaid not only impacts millions of people, it implicates billions of dollars. The Congressional Budget Office has estimated that exchange subsidies and related spending, as well as the increased Medicaid and CHIP outlays under the law, cost Federal taxpayers \$77 billion just in 2015 alone. The total cost for exchange and Medicaid-related spending next year, due to the law, jumps to \$116 billion.

Today's hearing comes at a critical time. Today, we are just over a week away from the start of open enrollment for federally subsidized exchange coverage under the Affordable Care Act.

So it is important that we examine the administration's actions taken, or not taken, to impact the accuracy of Medicaid and exchange coverage eligibility determinations and the Federal matching rate for State Medicaid expenditures.

Previous reports in 2014 and earlier this year from the non-partisan Department of Health and Human Services Office of Inspector General, the OIG, and the Government Accountability Office, the GAO, have raised very serious concerns about the systematic and ongoing vulnerabilities of eligibility verification systems in place governing the Healthcare.gov and state-operated health exchanges. It is important that today we not only get an update on the exchange systems, but also examine Federal efforts undertaken to ensure the accuracy of Medicaid eligibility determinations, and the Federal matching rate for state Medicaid expenditures. We will also look at the Federal and state procedures to minimize duplicative coverage for Medicaid and exchange premium subsidies. Regardless of member differences over the ACA, I hope we can all agree that good government need not be a partisan issue, and that protecting taxpayer dollars is a constitutional responsibility we all share.

Federal officials have a legal and ethical duty to be good stewards of Federal dollars and ensure programs operate within statutory requirements. If an individual is not eligible for a program, taxpayers should not be forced to subsidize that individual just because Federal controls are lax.

Our two witnesses today are from the GAO, and we appreciate their presence with us. They will share with us the data-driven assessment from the nonpartisan GAO regarding a range of challenges related to exchange eligibility controls and the Medicaid expansion.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

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insurance exchanges, and CMS's oversight of federal matching funds in the Medicaid program.

As we know, the ACA created taxpayer funded subsidies for health-care coverage for certain individuals and also required establishment of state-based or federally facilitated exchanges. As of June of this year, more than 9 million individuals have had effectuated exchange coverage—including more than 8 million individuals who are receiving federal subsidies.

The ACA also expanded Medicaid to cover childless adults, in what was the largest expansion of Medicaid since the program's creation in 1965. Since October 2013, more than 13 million individuals have been enrolled in Medicaid and CHIP—including at least 7.5 million newly-eligible individuals enrolled in Medicaid.

Whether or not CMS is making accurate determinations for the Exchanges and Medicaid not only impacts millions of people, it implicates billions of dollars. The Congressional Budget Office has estimated that Exchange subsidies and related spending—as well as the increased Medicaid and CHIP outlays under the law—cost federal taxpayers \$77 billion just in 2015 alone. The total cost for Exchange and Medicaid related spending next year due to the law jumps to \$116 billion dollars.

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It is important that today we not only get an update on the Exchange systems, but also examine Federal efforts undertaken to ensure the accuracy of Medicaid eligibility determinations and the Federal matching rate for State Medicaid expenditures. We will also look at the Federal and State procedures to minimize duplicative coverage for Medicaid and exchange premium subsidies.

Regardless of member differences over the ACA, I hope we can all agree that good government need not be a partisan issue and that protecting taxpayer dollars is a constitutional responsibility we all share. Federal officials have a legal and ethical duty to be good stewards of federal dollars and ensure programs operate within statutory requirements. If an individual is not eligible for a program, taxpayers should not be forced to subsidize that individual just because federal controls are lax.

Our two witnesses today are from the GAO and we appreciate their presence with us. They will share with us the data-driven assessment from the non-partisan GAO regarding a range of challenges related to exchange eligibility controls and the Medicaid expansion.

I will now yield to the distinguished Member,

Mr. PITTS. I now recognize the ranking member of the subcommittee, Mr. Green.

**OPENING STATEMENT OF HON. GENE GREEN, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. GREEN. Thank you, Mr. Chairman.

Well, thank you, Mr. Chairman. And I can't agree more than what you said about good government is not a partisan issue, but I have to admit, the hearing this morning is—I am disappointed, because for one thing, our office didn't get the GAO report within the 48 hours we should have had to be able to properly prepare. And this is a hearing by ambush. It is just not the way this subcommittee ought to work. And I have a briefing, or I have a list of things of the GAO in their report. But again, I don't know if that is a game that was being played, because when I asked for it 3 days ago, we didn't have it. And then I was told that our staff got to see it, and it was taken back. That is not the way this Congress

ought to legislate, particularly in the Energy and Commerce Committee. I have been on the committee since 1997, and I hope this is not the standard we are going to be using. And I would like to unanimously consent to place my statement in the record. But again, I don't think any of our members have had the opportunity to look at the GAO. They couldn't release it to us because of the request from you all, from the Republican majority, and we would expect the courtesy of being able to get a report so we can actually prepare questions and a statement in response.

But I will start with saying——

Mr. PITTS. Will the gentleman yield just a moment?

The staff informs me that you received the embargoed reports on Monday, the same time we did, and testimony on Wednesday. We got it at the same time.

Mr. GREEN. When did they give us the report on GAO?

Mr. PITTS. On Monday.

Mr. GREEN. Well, from what I heard, last night when we were briefed, is that we got a copy of it, but then it was requested not to make copies of it and not to give it back. Again, I hope our staff doesn't play games like that with what we need to do.

Mr. PITTS. We will try to make sure you get them in plenty of time.

Mr. GREEN. Let me talk about some of the concerns I have about the findings presented in the hearing in the GAO undercover testing is preliminary. They were put in testimony form and given to the minority less than 2 days prior to the hearing. These findings are not generalized, by GAO's own admission. The investigation was based on a small, statistically insignificant number of GAO created fictitious secret shoppers. These secret shoppers are not representative of the average consumer. GAO used the Federal Government's resources and knowledge in forging documents. GAO knew all the fraud prevention safeguards that were placed in advance and had experience getting around these controls.

Mr. Chairman, I know of no Republican support for the Affordable Care Act. Frankly, you couldn't survive a primary if you did. But, again, we are legislators, and we shouldn't have a hearing where, if you want to go after the ACA, we will be glad to battle with you, because I can talk about the success it is. 17.6 million uninsured have obtained coverage through the lowest uninsured rate on record. In fact, that has been reported widely in the newspapers.

But again, I was hoping we would get past this and we would actually be legislating. If there are problems with the Affordable Care Act, then let's fix them. Some of the things that were in the bill are in the law now, are what the Senate put in. And believe me, I would like to change some of those. But again, to have a hearing in our Health Subcommittee without having adequate notice so we can even prepare for the GAO report. And again, I will yield back my time, I would ask unanimous consent to be able to place a statement on the record later.

Mr. PITTS. The chair recognizes vice chair of the full committee, Mrs. Blackburn, 5 minutes for her opening statement.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman.

And I want to welcome our witnesses. I am so pleased that you are here and that we have got a chance to talk about eligibility standards and the eligibility systems for Medicaid. And Obamacare has changed a lot of this, and we know that that focus that Obamacare has been on bolstering enrollment numbers. And it didn't matter what the cost was, it was get the numbers up. So they have really thrown the door open for fraud.

Now, I come from a state that has a track record of working through expansions and enrollment. I come from Tennessee, and we were the test case with TennCare. We were the test case for HillaryCare. You all are familiar with that story, and you know what happened in our State. It was rampant with abuse. We didn't need secret shoppers. We had people that were coming from Kentucky and Alabama and Georgia and North Carolina and Arkansas and Mississippi and jumping into the TennCare program. And we had a fraud unit. We had to go in. I was a State Senator, set up a fraud unit because the fraud was so rampant.

The reason, it turned out, was there was no verification or reverification of the eligibility standards. So people said, Hey, this is great. It is a "come on in, get what you want." And some of the cases that are there of the fraud that was rooted out and found are astounding. People that would enroll a spouse with dementia in the program, and then they would be driven by ambulance from another state to Tennessee for their doctor's appointments, return home, then put in long-term care facilities and nursing facilities, and how did they get by with it? Because there was no reverification and no checking on these eligibility standards. We know that fraud is a problem. I find it amazing that HHS responded to the GAO findings.

And, Mr. Chairman, I just want to read this quote. "It is important to consider whether it is likely that uninsured Americans would replicate the next actions the GAO took; namely, knowingly and willingly providing false information in violation of Federal law, which could subject the individual to up to a \$250,000 fine."

Does anyone realize how totally naive this statement from Meaghan Smith from HHS is? If you have someone who is terminally ill, and you can skirt the eligibility because you know there is no reverification, \$250,000? You bet. They are going to give it a shot, and see if they don't get caught, and if they can get by because there is no verification.

Mr. Chairman, I appreciate the attention to this issue. I appreciate that the GAO has done a report. If you want to go back and look at government-managed healthcare programs, you see that much of the growth, much of the escalation and the cost per enrollee rate comes down to fraud. I yield back.

Mr. PITTS. The chair thanks the gentlelady, now recognize the ranking member of the full committee, Mr. Pallone, for 5 minutes of his opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Mr. Chairman, I think we would both agree that this committee has a long history of working respectfully together even on the most difficult of topics, but unfortunately, that did not happen here today with this hearing. It seems to me that my colleagues want nothing more than a flashy, top-line message to justify their obsession with undermining the Affordable Care Act, the result of which is an attempt to take away healthcare coverage from millions of Americans. I say this partly because I received only one paper copy of each of the GAO reports under discussion from the majority approximately 72 hours before this hearing, despite the fact that my staff had asked for these reports for at least a week prior; and my staff had to push multiple times for a time briefly from the GAO on this preliminary so-called fake shopper undercover work, also the topic of today's hearing.

Meanwhile, the only documentation available regarding the fake shopper investigation was GAO's testimony, which was made available to our committee less than 48 hours ago, and this is not a positive reflection on this committee.

Let me also point out that while today's hearing may purport to be an honest examination of GAO's work, I question GAO's motives and methods. GAO is supposedly a nonpartisan body. Its mission is supposedly to help government work more effectively and efficiently, but it certainly is not meant to go undercover to create headlines and play I gotcha with Federal agencies.

What is GAO's goal here today? Basically trying to take coverage away for millions of fellow Americans? That is a pretty sad goal and certainly not something that they should be proud of. The fact that GAO refuses to provide CMS with the information on the fake identities it created so that the agency can learn from the GAO's work and fix potential vulnerabilities in the system runs counter to their mission. That is why I sent a letter this morning to GAO comptroller general, Gene Dodaro, outlining these and other growing concerns about GAO, and I hope he conducts an investigation of the policies of GAO in this case.

Mr. Chairman, I do not believe that today's hearing is about program integrity. It is just another example of Republicans' relentless and tone-deaf war on the Affordable Care Act. In addition to GAO's fake shopper investigation, we are here today about two additional reports. If it were not for Republicans' continual mission to undermine the ACA, these reports could have provided a good policy discussion. Both highlight important areas where the agency could—should continue to focus on the ACA's streamline on no-wrong-door policy. That policy rightfully allows consumers to apply for coverage on either the marketplace, or with their State Medicaid agency to ensure appropriate healthcare coverage.

Importantly, the reports highlight the extent of the amount of work the Federal Government and States have done to improve these processes. In fact, CMS is already implementing all GAO's recommendations. But I cannot say the same for the preliminary fake shopper investigation. Let me be clear, Democrats are not opposed to program integrity. However, using fake identities and fake

documents is not a fear or realistic test of the accuracy and effectiveness of the eligibility enrollment system in the new healthcare marketplace. In fact, no reality exists in which a person can financially gain from gaming the system. At best, someone would pay an insurance company a monthly premium, pay their deductible, all to get well from an illness or disease.

And this is not some charlatan's trick. What is it that the GAO is trying to accomplish here? I would like to know to what extent. My understanding, and I am going to ask this in my question, is that you are Federal employees. You get your health insurance through the Federal employee program. There are a lot of people that don't get health insurance that easily and have to go through the system with the exchange. And it is often difficult for them to do that. And I understand that it is difficult, and I understand that there are problems. But for you to spend your time and your effort, taxpayer money, in trying to make it more difficult or somehow highlight the difficulties, I just don't understand.

It is inconceivable to me that some of the most vulnerable individuals in this country would have the desire, time, money, and expertise to try over and over again to fraudulently gain coverage. In fact, I worry that some of our country's neediest individuals end up forgoing coverage because the system is so confusing to them. And I want to commend HHS for criticizing the way GAO went about this, frankly.

Mr. Chairman, all of GAO's fake shoppers that went through the healthcare Web site failed the identity check. They were all required under penalty of perjury to submit additional documents at which point GAO provided counterfeit information, such as fictitious Social Security cards and immigration documents. Further, GAO stopped short of filing tax returns for the fake shoppers. That makes it clear to me that we have important controls in place.

Republicans have said that Democrats care too much about insuring people and access coverage, and that is an accusation that I am proud to own. I do believe that priority should be first and foremost that people can access the coverage they need or are entitled to have, and I am proud to have been the chief architect of the law that helps that happen.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

Again, let me just briefly reiterate, the minority received the testimony on Wednesday, when we received it. I am told the GAO briefed the minority last Friday, and we provided the full report on Monday to your office, Mr. Pallone, which I understand you distributed to the member offices.

So we gave the minority more info and lead time than required under the rules. And this hearing is about accountability, which all of us want.

So, with that, sorry to have this start on a partisan note, but that concludes the members' opening statements. As usual, all members' written opening statements will be made part of the record, and we will proceed to our panel.

Our two witnesses today are from the GAO, and we appreciate their presence with us. They will share with us the data-driven assessment from the nonpartisan GAO regarding a range of chal-

lenges related to exchange eligibility controls and the Medicaid expansion.

And on our panel we have Ms. Carolyn Yocom, Director, Health Care, Government Accountability Office; and Mr. Seto Bagdoyan, Director, Audit Services, Forensic and Investigative Services, General Accountability Office.

Thank you for coming today. Your written testimony will be made a part of the record. You will each be given 5 minutes to summarize your written testimony.

And, Ms. Yocom, we will start with you. You are recognized for 5 minutes for your summary.

STATEMENTS OF CAROLYN YOCOM, DIRECTOR, HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE; AND SETO BAGDOYAN, DIRECTOR, AUDIT SERVICES, FORENSIC AND INVESTIGATIVE SERVICE, GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF CAROLYN YOCOM

Ms. YOCOM. Thank you. Chairman Pitts, Ranking Member Green, and members of the subcommittee, I am pleased to be here today to discuss issues related to CMS oversight of Medicaid eligibility determination, and coordination between Medicaid and the health insurance exchanges, which are also referred to as marketplaces.

The Patient Protection and Affordable Care Act has provided millions of Americans new options for obtaining health insurance by qualifying for Medicaid, or purchasing private insurance through a state-based or federally-facilitated exchange. Because income volatility occurs for many low-income individuals, they are likely to switch between Medicaid and subsidized exchange coverage. It has been estimated that 6.9 million individuals who receive either Medicaid or the exchanges will switch between coverage some time during the year.

Due to the likelihood of these transitions, the Act requires coordination between Medicaid and the exchanges. However, the complexity of designing such coordinated processes can raise challenges, and careful CMS oversight is crucial to ensure that Medicaid eligibility determinations are appropriate, and that the risk of coverage gaps and duplicate coverage is minimized. My statement draws from two reports and will focus on, first, CMS oversight of enrollment of beneficiaries and reporting of expenditures; and, secondly, the extent to which CMS and States have policies and procedures in place to reduce the potential for coverage gaps and duplicate coverage when individuals transition between Medicaid and the exchange.

Regarding Medicaid enrollment, CMS has taken some interim steps to review the accuracy of state eligibility determination and examine state expenditures for different eligibility groups, but more efforts are required. In particular, CMS has excluded Federal eligibility determinations from their review. This creates a gap in efforts to ensure that only eligible individuals are enrolled in Medicaid, and that state expenditures are correctly matched by the Federal Government.

CMS also does not use information from these eligibility reviews to better target its oversight of Medicaid expenditures for the different eligibility groups. Consequently, CMS cannot identify erroneous expenditures due to incorrect eligibility determinations.

To improve its oversight, we recommended, and CMS generally agreed, that CMS should review Federal determinations of Medicaid eligibility for accuracy and use the information obtained from State and Federal eligibility reviews to inform its review of expenditures for different eligibility groups.

With regard to coordination between Medicaid and the exchanges, CMS has implemented several policies and procedures, and has additional controls planned to minimize the potential for coverage gaps and duplicate coverage. However, we found weaknesses in internal controls for the Federal exchanges. For example, CMS's controls do not provide reasonable assurance that electronic records for individuals transitioning from Medicaid to exchange coverage are transferred by states in near real time, thus putting individuals at greater risk for experiencing gaps in coverage. We also found weaknesses in CMS's controls for preventing, detecting, and resolving duplicate coverage.

To further minimize the risk of coverage gaps and duplicate coverage, we recommended, and CMS agreed, that CMS take three actions: First, to routinely monitor the timeliness of account transfers from states; secondly, to establish a schedule for regular checks of duplicate coverage; and then, thirdly, to develop a plan to monitor the effectiveness of these checks. CMS did report a number of planned steps to address the risks that we identified.

Chairman Pitts, Ranking Member Green, and members of the subcommittee, this concludes my statement, and I would be pleased to respond to any questions.

[The prepared statement of Ms. Yocom follows:]

United States Government Accountability Office



Testimony

Before the Subcommittee on Health,
Committee on Energy and Commerce,
House of Representatives

For Release on Delivery
Expected at 9:00 a.m. ET
Friday, October 23, 2015

MEDICAID

Additional Federal Controls Needed to Improve Accuracy of Eligibility Determinations and for Coordination with Exchanges

Statement of Carolyn L. Yocom
Director, Health Care

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

I am pleased to be here today to discuss our recent reports that are being released today examining issues related to federal oversight of Medicaid eligibility determinations and coordination between Medicaid and the exchanges.¹

Beginning in 2014, the Patient Protection and Affordable Care Act (PPACA) provided millions of low-income Americans new options for obtaining health insurance coverage—through the Medicaid program or by purchasing private health insurance through an exchange.²

- As one of the largest sources of health care coverage in the nation, Medicaid covered about 72 million individuals in fiscal year 2013. Under PPACA, states could choose to expand coverage to eligible individuals whose incomes are at or below 133 percent of the federal poverty level (FPL).³ Both states and the federal government share in the financing of Medicaid, with increased federal matching funds available for enrollees covered under the expansion beginning in January 2014. To receive the increased matching funds, states must provide data on Medicaid enrollment and expenditures to the Centers

¹GAO, *Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds*, GAO-16-53 (Washington, D.C.: October 16, 2015) and GAO, *Medicaid and Insurance Exchanges: Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage*, GAO-16-73 (Washington, D.C.: October 9, 2015).

²Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010). For the purposes of this testimony, references to PPACA include the amendments made by HCERA.

³For the purposes of this testimony, we consider the District of Columbia a state. Medicaid is a joint federal-state program that finances health insurance coverage for certain categories of low-income and medically needy individuals. PPACA provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the FPL.

for Medicare & Medicaid Services (CMS), which oversees Medicaid.⁴ As of September 2015, 30 states had expanded their Medicaid programs.⁵

- PPACA required the establishment of health insurance exchanges—that is, marketplaces where eligible individuals may compare and select among private health plans—in all states and provided for federal subsidies to assist qualifying low-income individuals in paying for exchange coverage.⁶ States may elect to establish and operate an exchange, known as a state-based exchange, or allow CMS—which is responsible for overseeing the exchanges—to do so within the state, known as a federally facilitated exchange (FFE).⁷ As of March 2015, CMS operated an FFE in 34 states, and 17 states were approved to operate state-based exchanges.⁸

⁴CMS is an agency within the Department of Health and Human Services (HHS). The federal government matches most state expenditures for Medicaid services on the basis of a statutory formula based in part on a state's per capita income. Federal law specifies that this federal match may range from 50 to 83 percent. Under PPACA, increased federal matching rates are available for individuals who were not eligible for Medicaid under historic eligibility rules but receive coverage through (1) a state option to expand Medicaid under PPACA, or (2) a state's qualifying expansion of coverage prior to PPACA's enactment.

⁵An additional state, Montana, took steps to expand its Medicaid program, with the expansion pending federal approval. See Kaiser Family Foundation State Health Facts, "Status of State Action on the Medicaid Expansion Decision," updated September 1, 2015, accessed October 14, 2015, <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

⁶CMS commonly refers to the exchanges as marketplaces. Where we discuss exchanges in this testimony, we are referring only to the individual exchanges, rather than the small business exchanges also required under PPACA. We refer to health plans purchased through the exchanges as exchange coverage and enrollment in exchange coverage with federal subsidies as subsidized exchange coverage. Federal subsidies for exchange coverage include premium tax credits, which are available to eligible individuals with incomes between 100 and 400 percent of the FPL and who do not have access to minimum essential coverage, including most Medicaid coverage. In addition, subsidies may include cost-sharing reductions for eligible individuals with incomes between 100 and 250 percent of the FPL. Medicaid plans that provide less than full benefits do not constitute minimum essential coverage and therefore do not preclude individuals from being eligible for subsidized exchange coverage.

⁷In this testimony, we refer to states with federally facilitated exchanges as FFE states.

⁸States with state-based exchanges may use the FFE information technology systems for eligibility and enrollment functions. In 2014, two states with state-based exchanges used the FFE information technology systems for eligibility and enrollment, while in 2015 three states with state-based exchanges did so.

Many low-income individuals experience income volatility and are therefore likely to transition between Medicaid and subsidized exchange coverage. PPACA required the creation of a coordinated eligibility and enrollment process for Medicaid and the exchanges to streamline the eligibility determination process and to ensure that individuals are (1) enrolled in the coverage for which they are eligible, and (2) transferred to the appropriate form of coverage if their eligibility changes. Streamlining eligibility determinations necessitated the adoption of new policies and information technology systems by the states, and can require significant coordination between states and the federal government. Previous research has estimated that 6.9 million, or 7 percent, of individuals who receive either Medicaid or exchange subsidies will experience a change in eligibility from one to the other each year.⁹ Given the complexity of designing coordinated policies and systems to facilitate Medicaid and exchange eligibility and enrollment, challenges could arise during the transition process. In particular, individuals may experience gaps in coverage, which can lead to individuals forgoing necessary care, or become simultaneously enrolled in both Medicaid and subsidized exchange coverage (referred to as duplicate coverage), which is generally not permitted under federal law.¹⁰ Careful CMS oversight is crucial to ensure that determinations of Medicaid eligibility are appropriate, and that the risk of coverage gaps and duplicate coverage is minimized for individuals transitioning between the coverage types.

My statement draws from two reports that are being released today and will focus on:

1. CMS oversight of state enrollment of beneficiaries, and reporting of expenditures; and
2. the extent to which CMS and states had policies and procedures to minimize the potential for coverage gaps and duplicate coverage when individuals transition between Medicaid and exchange coverage.

⁹See M. Buettgens, A. Nichols, and S. Dorn, *Churning Under the ACA and State Policy Options for Mitigation*, (Washington, D.C.: Urban Institute and Robert Wood Johnson Foundation, June 2012).

¹⁰Individuals enrolled in subsidized exchange coverage who are found to be eligible for Medicaid are permitted to be enrolled in both types of coverage through the end of the month of the eligibility determination. See 26 U.S.C. § 36B(c)(2)(A)-(B); 26 C.F.R. § 1.36B-2(c)(iv).

To examine CMS oversight of state enrollment of beneficiaries and reporting of expenditures, we examined relevant federal laws and regulations, federal internal control standards,¹¹ CMS guidance and oversight tools, and interviewed CMS officials.¹² To examine the extent to which the federal government and states had policies and procedures that minimize the potential for coverage gaps and duplicate coverage, we reviewed relevant federal regulations and guidance, FFE documentation, and federal internal control standards, and interviewed CMS officials. We also collected information from eight states selected, among other factors, to include four FFE states.¹³ The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards.

In brief, while CMS has taken some actions, we found gaps in its oversight of Medicaid enrollment resulting from the PPACA expansion. CMS is missing opportunities that per federal internal control standards would better ensure the accuracy of eligibility determinations in all states, and also ensure that Medicaid expenditures for different eligibility groups are appropriately matched with federal funds. In regard to coordination between Medicaid and the exchanges, CMS implemented several policies and procedures, and has additional controls planned that represent positive steps toward minimizing the potential for coverage gaps and duplicate coverage in FFE states. However, as per federal internal control standards, those plans do not sufficiently address the risks. These gaps are further described below.

Oversight of Medicaid Enrollment

CMS has implemented interim measures to review the accuracy of state eligibility determinations and examine states' expenditures for different eligibility groups, for which states may receive up to three different federal matching rates. However, we found that CMS has excluded from review federal Medicaid eligibility determinations in the states that have delegated authority to the federal government to make Medicaid eligibility

¹¹Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives. See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

¹²For additional information on our methodology, see GAO-16-53.

¹³For additional information on our methodology, see GAO-16-73.

determinations through the FFE. As a result, we determined that this creates a gap in efforts to ensure that only eligible individuals are enrolled into Medicaid, and that state expenditures are appropriately matched by the federal government.

In addition, we found that CMS reviews of states' expenditures do not use information obtained from the reviews of state eligibility determination errors to better target its review of Medicaid expenditures for the different eligibility groups. An accurate determination of these different eligibility groups is critical to ensuring that only eligible individuals are enrolled, that they are enrolled in the correct eligibility group, and that states' expenditures are appropriately matched with federal funds for Medicaid enrollees. Consequently, we concluded that CMS cannot identify erroneous expenditures due to incorrect eligibility determinations, which also limits its ability to ensure that state expenditures are appropriately matched with federal funds.

To improve the effectiveness of its oversight determinations and increase assurances that states receive an appropriate amount of federal matching funds, we recommended that CMS (1) review federal determinations of Medicaid eligibility for accuracy, and (2) use the information obtained from state and federal eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and appropriately matched. The agency generally concurred with our recommendations.

Coordination between Medicaid and Exchanges

CMS's policies and procedures do not sufficiently minimize the potential for coverage gaps and duplicate coverage in FFE states. We found that individuals transitioning from Medicaid to exchange coverage may experience coverage gaps, for example, if they lose Medicaid eligibility toward the end of a month. Individuals who experience coverage gaps may decide to forgo necessary care. In addition, we found that some individuals had duplicate coverage. While some amount of duplicate coverage is permissible under federal law—and may be expected during the transition from exchange to Medicaid coverage—we found that duplicate coverage was also occurring under other scenarios, such as when individuals do not end their subsidized exchange coverage after being determined eligible for Medicaid. Individuals may be held liable for repaying certain exchange subsidies received during the period of duplicate coverage. Further, the federal government could be paying twice—subsidizing exchange coverage and reimbursing states for Medicaid spending—for individuals enrolled in both types of coverage.

While CMS has implemented policies and procedures that help minimize the potential for coverage gaps and duplicate coverage, we identified weaknesses in CMS's controls for FFE states based on federal internal control standards.¹⁴ Specifically, we found that CMS's controls do not provide reasonable assurance that accounts—that is, electronic records—for individuals transitioning from Medicaid to exchange coverage in FFE states are transferred in near real time, putting individuals at greater risk of experiencing coverage gaps. In addition, we found weaknesses in CMS's controls for preventing, detecting, and resolving duplicate coverage in FFE states—for example, CMS had no specific plan for monitoring the effectiveness of planned periodic checks for duplicate coverage, making it difficult for the agency to provide reasonable assurance that its procedures are sufficient or whether additional steps are needed.

Our findings based on three states in 2014 also indicate that a relatively small proportion of Medicaid and exchange enrollees transitioned between the coverage types in 2014, and thus the incidence of coverage gaps and duplicate coverage could be limited. However, to the extent that transitions increase in the future—particularly if exchange enrollment continues to grow and if additional states expand Medicaid—improvements to CMS controls to minimize coverage gaps and duplicate coverage will be increasingly important.

To better minimize the risk of coverage gaps and duplicate coverage for individuals transitioning between Medicaid and the exchanges in FFE states, we recommended that CMS take three actions, including (1) routinely monitoring the timeliness of account transfers from states, (2) establishing a schedule for regular checks for duplicate coverage, and (3) developing a plan to monitor the effectiveness of the checks. The agency concurred with our recommendations and summarized planned steps to address these risks.

¹⁴Consistent with federal internal control standards, in its responsibilities for administering and overseeing Medicaid and the exchanges, CMS should design and implement necessary policies and procedures to achieve agency objectives and assess program risk. These policies and procedures should include internal controls, such as conducting monitoring to assess performance over time, that provide reasonable assurance that an agency has effective and efficient operations, and that program participants are in compliance with applicable laws and regulations.

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions you may have.

**GAO Contact and
Staff
Acknowledgments**

If you or your staff have any questions about this testimony, please contact Carolyn L. Yocom, Director, Health Care at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Susan Barnidge, Assistant Director; Robert Copeland, Assistant Director; Priyanka Sethi Bansal; Corissa Kiyan; Drew Long; and Jessica L. Preston.

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Mr. PITTS. The chair thanks the gentlelady, and now recognizes Mr. Bagdoyan 5 minutes for his summary.

STATEMENT OF SETO BAGDOYAN

Mr. BAGDOYAN. Thank you. Chairman Pitts, Ranking Member Green, and members of the subcommittee, I am pleased to be here today to discuss the preliminary results of GAO's undercover tests assessing the enrollment controls of the Federal marketplace and selected state marketplaces under the ACA for coverage year 2015.

We performed 18 undercover tests through phone or online applications. Our tests were designed specifically to identify indicators of potential control weaknesses, and inform our separate forensic audits of these controls, which cover the entire universe of enrollees. I would note that our results, while illustrative, cannot be generalized, as pointed out earlier, to the entire applicant population. We did discuss details of our observations extensively, both with CMS and the selected states, to seek their responses to the issues we identified.

CMS and state officials explained, for example, that in the applicable instances, the marketplaces and Medicaid agencies are only required to inspect application documentation for obvious alteration. If there are no signs of alteration, the documents won't be questioned for their authenticity.

In terms of context, health coverage offered through the marketplaces is a significant expenditure for the Federal Government, as Chairman Pitts pointed out.

Current levels of coverage involve several million enrollees, of whom about 85 percent are receiving subsidies. CBO pegs subsidy costs for fiscal year 2016 at about \$60 billion, and a total of \$880 billion for fiscal years 2016 to 2025.

I would note that while subsidies are paid to insurers and not directly to enrollees, they nevertheless represent a financial benefit to them. I would also note that a program of this scope and scale, millions of enrollees and hundreds of billions of dollars in expenditures, is inherently at risk for errors, including improper payments and fraudulent activity.

Accordingly, it is essential that there are effective enrollment controls in place to help narrow the window of opportunity for such risk, and safeguard the government's investment in the program.

With this as backdrop, I will now discuss our test principal results.

Overall, we first observed no year-on-year improvements in the Federal marketplace's controls from our coverage year 2014 tests. Second, we found similar control vulnerabilities in the state marketplaces. And third, following the system's own instructions, employed relatively simple workarounds such as making phone calls and making self-attestations to circumvent the controls we did encounter to obtain coverage.

More specifically, the Federal and selected state marketplaces approved subsidized coverage, either private plans or Medicaid, for 17 of our 18 fictitious applicants. The subsidies totaled about \$41,000 on an annualized basis.

For 10 applicants, we tested application enrollment into subsidized qualified health plans, or QHPs, available through the Fed-

eral marketplace to include the States of North Dakota and New Jersey, and state marketplaces in Kentucky and California. These applicants were directed to submit supporting documents, such as proof of income or citizenship, and submitted fake documents in response. In each instance, the Federal or state marketplaces approved coverage. This included four applications where we used Social Security numbers that could not have been issued by the Social Security Administration.

For the remaining eight applicants, we tested Medicaid enrollment through the Federal marketplace as a portal for North Dakota and New Jersey, and State marketplaces in California and Kentucky.

For three of eight applications, we were approved for Medicaid. In each of these tests, we provided identity information that would not match SSA records. Each applicant was directed to submit supporting documents. Again, we submitted fake documents, and the applications were approved.

For four of eight applications, we were unable to obtain Medicaid approval; however, as a result of this failure, we subsequently applied for and were approved for subsidized qualified health plans. For the remaining application, we were unable to apply for Medicaid coverage in California, because the applicant declined to provide a Social Security number, citing privacy concerns.

In closing, our results highlight the need for CMS and the states to make program integrity a priority and implement effective controls to help reduce the risks for potential improper payments and fraud. Otherwise, there is significant potential for such risks to be embedded early in a major new benefits program such as the ACA. We plan to include a number of recommendations to CMS regarding controls in a forthcoming report, and we have already discussed these recommendations in detail, including with Acting Administrator Slavitt.

Mr. Chairman, this concludes my statement. I look forward to the subcommittee's questions.

[The prepared statement of Mr. Bagdoyan follows:]



United States Government Accountability Office

Testimony

Before the Subcommittee on Health,
Committee on Energy and Commerce,
House of Representatives

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015

Statement of Seto Bagdoyan, Director, Forensic Audits
and Investigative Service

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

I am pleased to be here today to discuss enrollment for health-care coverage obtained through the health-insurance exchanges, or marketplaces, established under the Patient Protection and Affordable Care Act (PPACA) and, in particular, to discuss the preliminary results of our undercover testing of eligibility and enrollment controls for the federal Health Insurance Marketplace (Marketplace) and selected state marketplaces for the 2015 coverage year. PPACA provides subsidies to those eligible to purchase private health-insurance plans who meet certain income and other requirements. With those subsidies and other costs, the act represents a significant, long-term fiscal commitment for the federal government. According to the Congressional Budget Office, the estimated cost of subsidies and related spending under the act is \$60 billion for fiscal year 2016, rising to \$105 billion for fiscal year 2025, and totaling \$880 billion for fiscal years 2016–2025.¹

While subsidies under the act are not paid directly to enrollees, participants nevertheless benefit financially through reduced monthly premiums or lower costs due at time of service, such as copayments.² Because subsidy costs are contingent on who obtains coverage, enrollment controls that help ensure only qualified applicants are approved for subsidized coverage are a key factor in determining federal expenditures under the act.³ In addition, PPACA provided for the expansion of the Medicaid program.⁴ Under the expansion, states may

¹Related spending includes marketplace grants to states and other items.

²Enrollees can pay lower monthly premiums by virtue of a tax credit the act provides. They may elect to receive the tax credit in advance, to lower premium cost, or to receive it at time of income-tax filing, which reduces tax liability.

³According to Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) data, about 11.7 million people selected or were automatically reenrolled into a 2015 health insurance plan under the act. A large share of those enrollees—87 percent, in states using the HealthCare.gov system—qualified for the advance premium tax-credit subsidy provided by the act, which is described later in this statement.

⁴PPACA provides states with additional federal funding to expand their Medicaid programs to cover adults under 65 with income up to 133 percent of the federal poverty level. Because of the way the limit is calculated, using what is known as an "income disregard," the level is effectively 138 percent of the federal poverty level.

choose to provide Medicaid coverage to nonelderly adults who meet income limits and other criteria. Under PPACA, the federal government is to fully reimburse states through fiscal year 2016 for the Medicaid expenditures of "newly eligible" individuals who gained Medicaid eligibility through the expansion.⁵ According to the Office of the Actuary of the Centers for Medicare & Medicaid Services (CMS), federal expenditures for the Medicaid expansion are estimated at \$430 billion from 2014 through 2023.⁶

PPACA provides for the establishment of health-insurance marketplaces to assist consumers in comparing and selecting among insurance plans offered by participating private issuers of health-care coverage.⁷ Under PPACA, states may elect to operate their own health-care marketplaces, or they may rely on the federal Marketplace, known to the public as HealthCare.gov.⁸ These marketplaces were intended to provide a single point of access for individuals to enroll in private health plans, apply for income-based subsidies to offset the cost of these plans—which, as noted, are paid directly to health-insurance issuers—and, as applicable, obtain an eligibility determination or assessment of eligibility for other health-coverage programs, such as Medicaid or the Children's Health Insurance Program.⁹ CMS, a unit of the Department of Health and Human

⁵The "newly eligible" reimbursement rate drops to 95 percent in calendar year 2017, 94 percent in calendar year 2018, 93 percent in calendar year 2019, and 90 percent afterward.

⁶According to the CMS Office of the Actuary, an average of 4.3 million newly eligible adults are projected to have been enrolled in Medicaid in 2014, with newly eligible adult enrollment projected to reach 12.0 million people by 2023—representing 7 percent and 15 percent, respectively, of total projected program enrollment. Expenditures for newly eligible adults are estimated to have been \$23.7 billion in 2014 and are projected to total \$460 billion over 2014 through 2023, according to the actuary. About \$430 billion, or 93 percent, of these costs are expected to be paid by the federal government.

⁷Specifically, the act required, by January 1, 2014, the establishment of health-insurance marketplaces in all states. In states not electing to operate their own marketplaces, the federal government was required to operate a marketplace.

⁸As of March 2015, 37 states were using HealthCare.gov, according to HHS' Office of the Assistant Secretary for Planning and Evaluation, with the federal Marketplace accounting for 76 percent (8.8 million) of consumers' plan selections.

⁹Individuals may also continue to apply for Medicaid coverage or the Children's Health Insurance Program through direct application to their respective state agencies. According to CMS officials, eligibility requirements are generally the same for both programs. In this statement, our testing was only for Medicaid eligibility.

Services (HHS), is responsible for overseeing the establishment of these online marketplaces, and the agency maintains the federal Marketplace.

To be eligible to enroll in a "qualified health plan" offered through a marketplace—that is, one providing essential health benefits and meeting other requirements under PPACA—an individual must be a U.S. citizen or national, or otherwise lawfully present in the United States; reside in the marketplace service area; and not be incarcerated (unless incarcerated while awaiting disposition of charges).¹⁰ To be eligible for Medicaid, individuals must meet federal requirements regarding residency, U.S. citizenship or immigration status, and income limits, as well as any additional state-specific criteria that may apply.

Marketplaces are required by PPACA to verify application information to determine eligibility for enrollment and, if applicable, determine eligibility for the income-based subsidies or Medicaid. These verification steps include validating an applicant's Social Security number, if one is provided;¹¹ verifying citizenship, status as a national, or lawful presence by comparison with Social Security Administration or Department of Homeland Security records; and verifying household income and family size by comparison with tax-return data from the Internal Revenue Service, as well as data on Social Security benefits from the Social Security Administration.¹²

In light of the government's substantial fiscal commitment under the act, congressional requesters originally asked us to examine enrollment and

¹⁰In this statement, we use "qualified health plan" to refer to coverage obtained from private insurers, as distinguished from enrollment in a public health program such as Medicaid.

¹¹A marketplace must require an applicant who has a Social Security number to provide the number. 42 U.S.C. § 18081(b)(2) and 45 C.F.R. § 155.310(a)(3)(i). However, having a Social Security number is not a condition of eligibility.

¹²For further background, see Department of Health and Human Services, Office of Inspector General, *Not All of the Federally Facilitated Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Properly Determined Eligible for Qualified Health Plans and Insurance Affordability Programs*, A-09-14-01011 (Washington, D.C.: Aug. 6, 2015); GAO, *Patient Protection and Affordable Care Act: IRS Needs to Strengthen Oversight of Tax Provisions for Individuals*, GAO-15-540 (Washington, D.C.: July 29, 2015); and GAO, *Healthcare.gov: CMS Has Taken Steps to Address Problems, but Needs to Further Implement Systems Development Best Practices*, GAO-15-238 (Washington, D.C.: Mar. 4, 2015).

verification controls of the federal Marketplace.¹³ In July 2014, we presented testimony on the results of our initial work, which focused on application for, and approval of, coverage for fictitious applicants for the 2014 coverage year—the first under the act—through the federal Marketplace.¹⁴ In July 2015, we testified on the final results of that work, including the maintenance of the fictitious applicant identities and extension of coverage through 2014 and into 2015, payment of federally subsidized premiums on policies we obtained, and the Marketplace's verification process for applicant documentation.¹⁵ We plan to issue a final report on the results of our undercover eligibility and enrollment controls testing for the 2014 coverage year shortly.

Following the original request, you and other congressional requesters asked us to continue to examine enrollment and verification controls of the federal Marketplace and state marketplaces as well, for the 2015 coverage year—the second under the act. My statement today is based on the preliminary results and analysis from this ongoing work.¹⁶ Specifically, today's statement describes the preliminary results of our undercover testing of the federal Marketplace and selected state marketplaces, for application, enrollment, and eligibility-verification controls, for both qualified health-care plans and Medicaid, during the

¹³Our original requesters were: in the U.S. Senate, the then-Ranking Member of the Committee on Homeland Security and Government Affairs and the then-Ranking Member of the Committee on Finance; and in the House of Representatives, the then-Chairman of the Committee on Ways and Means and the then-Chairman of the Subcommittee on Oversight, Committee on Ways and Means.

¹⁴GAO, *Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act*, GAO-14-705T (Washington, D.C.: July 23, 2014).

¹⁵GAO, *Patient Protection and Affordable Care Act: Observations on 18 Undercover Tests of Enrollment Controls for Health-Care Coverage and Consumer Subsidies Provided under the Act*, GAO-15-702T (Washington, D.C.: July 16, 2015).

¹⁶Our original requesters are: in the U.S. Senate, the Chairman of the Committee on Finance; and in the House of Representatives, the Chairman of the Committee on Energy and Commerce, the Chairman of the Subcommittee on Health, Committee on Energy and Commerce; the former Chairman of the Committee on Ways and Means and the former Chairman of the Subcommittee on Oversight, Committee on Ways and Means.

act's second open-enrollment period ending February 2015.¹⁷ We plan to issue a final report at a later date.

To perform our undercover testing of the federal and selected state eligibility and enrollment processes for the 2015 coverage year, we created 18 fictitious identities for the purpose of making applications for health-care coverage by telephone and online.¹⁸ The undercover results, while illustrative, cannot be generalized to the full population of enrollees. For all 18 applications, we used publicly available information to construct our scenarios. We also used publicly available hardware, software, and materials to produce counterfeit or fictitious documents, which we submitted, as appropriate for our testing, when instructed to do so. We then observed the outcomes of the document submissions, such as any approvals received or requests to provide additional supporting documentation.

Because the federal government, at the time of our review, operated a marketplace on behalf of the state in about two-thirds of the states, we focused part of our work on two states using the federal Marketplace—New Jersey and North Dakota. We chose these two states because they had expanded Medicaid eligibility and also delegated their Medicaid eligibility determinations to the federal Marketplace at the time of our testing.¹⁹ In addition, we chose two state marketplaces, California and Kentucky, for our undercover testing. We chose these two states, in part, based on the states having expanded Medicaid eligibility and differences in population.

For 10 applicant scenarios, we tested controls for verifications related to qualified health-plan coverage. Specifically, we created application

¹⁷Our testing included only applications through a marketplace and did not include, for example, applications for Medicaid made directly to a state Medicaid agency.

¹⁸For all our applicant scenarios, we sought to act as ordinary consumers might in attempting to make a successful application. For example, if, during online applications, we were directed to make phone calls to complete the process, we acted as instructed.

¹⁹According to CMS officials, for states that have delegated the determinations, the federal Marketplace will make an eligibility determination if there are no application "inconsistencies"—instances in which information an applicant has provided does not match information contained in data sources used for eligibility verification at the time of application, or such information is not available. If there are inconsistencies, state Medicaid agencies make the determination.

scenarios with fictitious applicants claiming to have impossible Social Security numbers;²⁰ claiming to be working for an employer that offers health insurance, but not coverage that meets "minimum essential" standards; or already having existing qualified health-plan coverage.²¹ We made 4 of these 10 applications online and the other 6 applications by phone. In these tests, we also stated income at a level eligible to obtain both types of income-based subsidies available under PPACA—a premium tax credit, to be paid in advance, and cost-sharing reduction.²²

For 8 additional applicant scenarios, we tested controls for verifications related to Medicaid coverage.²³ Specifically, our fictitious applicants provided invalid Social Security identities, where their information did not match Social Security Administration records, or claimed they were noncitizens lawfully present in the United States and declined to provide Social Security numbers.²⁴ In situations where we were asked to provide immigration document numbers, we provided impossible immigration

²⁰According to the Social Security Administration Program Operations Manual System, the Social Security Administration has never issued a Social Security number with the first three digits as "000," "666," or in the 900 series; the second group of two digits as "00"; or the third group of four digits as "0000."

²¹In the case of the employer-provided coverage, we created a fictitious company with fictitious employer contact information. For the existing-coverage testing, we used an identity that had previously obtained coverage during our testing of enrollment for coverage-year 2014; see GAO-15-702T.

²²To qualify for these income-based subsidies, an individual must be eligible to enroll in marketplace coverage; meet income requirements; and not be eligible for coverage under a qualifying plan or program, such as affordable employer-sponsored coverage, Medicaid, or the Children's Health Insurance Program. Cost-sharing reduction is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments. Because the benefit realized through the cost-sharing reduction subsidy can vary according to medical services used, the value to consumers of such subsidies can likewise vary.

²³According to CMS officials, when an individual applies through a marketplace for coverage with financial assistance, they complete a single application that is an application for all insurance affordability programs; that is, individuals do not apply specifically for individual programs such as Medicaid. For our Medicaid testing, we applied using an income level we selected as eligible for Medicaid coverage. On that basis, we refer to our "Medicaid applications" throughout this statement. The application is signed under penalty of perjury, the officials noted.

²⁴Note that we distinguish between impossible Social Security numbers—numbers never issued—and invalid Social Security identities—in which applicant-submitted information does not match Social Security Administration records.

document numbers.²⁵ We made half of these applications online and half by phone. In these tests, we also stated income at a level eligible to qualify for coverage under the Medicaid expansion, where the federal government is responsible for reimbursing the states for 100 percent of the Medicaid costs in 2015. In cases where we did not obtain approval for Medicaid, we instead attempted, as appropriate, to obtain coverage for subsidized qualified health plans in the same manner as described earlier.

After concluding our undercover testing, we briefed officials from CMS; officials from the state marketplaces; and Medicaid officials from California, Kentucky, and North Dakota on our results. We asked to brief Medicaid officials from New Jersey but they declined our request. To protect our undercover identities, we did not provide the marketplaces with specific applicant identity information. CMS and selected state officials generally told us that without such information, they could not fully research handling of our applicants. We also reviewed laws, regulations, and other policy and related information.

We are conducting the work upon which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We are conducting our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

²⁵Specifically, we provided numbers that did not match the format for the document(s) at issue.

**Preliminary Results of
Undercover Attempts
to Obtain Qualified
Health-Plan
Coverage from the
Federal Marketplace
and Selected State
Marketplaces**

Our undercover testing for the 2015 coverage year found that the health-care marketplace eligibility determination and enrollment process remains vulnerable to fraud.²⁶ As shown in figure 1, the federal Marketplace or selected state marketplaces approved each of our 10 fictitious applications for subsidized qualified health plans.²⁷ We subsequently paid premiums to put these policies into force.

²⁶As noted earlier, we conducted similar undercover testing for the first open-enrollment period. See GAO-15-702T.

²⁷For our testing involving applications for qualified health-plan coverage, our fictitious applicants initially applied online or by telephone.

Figure 1: Summary of Outcomes for 10 Fictitious Applications for Subsidized Qualified Health-Plan Coverage

Marketplace	State	Initial application type	Scenario for testing	Obtained subsidized qualified health-plan coverage?	
► Federal					
	New Jersey	☎ Phone	Impossible Social Security number	✓ Yes	
		💻 Online	Employer-sponsored coverage not meeting "minimum essential" standards	✓ Yes	
	North Dakota	☎ Phone	Impossible Social Security number	✓ Yes	
		💻 Online	Employer-sponsored coverage not meeting "minimum essential" standards	✓ Yes	
	► State				
		California	☎ Phone	Impossible Social Security number	✓ Yes
💻 Online			Employer-sponsored coverage not meeting "minimum essential" standards	✓ Yes	
☎ Phone ^a			Duplicate enrollment	✓ Yes	
Kentucky		☎ Phone	Impossible Social Security number	✓ Yes	
		💻 Online	Employer-sponsored coverage not meeting "minimum essential" standards	✓ Yes	
		☎ Phone	Duplicate enrollment ^b	✓ Yes	

Source: GAO. | GAO-16-159T

^aWe initially applied by phone for coverage. At the time of application, the call representative stated that the data hub was not working and that we could send in the application by mail, fax it, or visit in person. We chose to mail the application with supporting documentation (for example, driver's license) to the state marketplace. We subsequently obtained coverage.

^bIn addition to obtaining coverage under a subsidized qualified health plan, we were also subsequently approved for Medicaid.

As the figure shows, for these 10 applications, we were approved for subsidized coverage—the premium tax credit, paid in advance, and cost-

sharing reduction subsidies—for all cases.²⁸ The monthly amount of the advance premium tax credit for these 10 applicants totaled approximately \$2,300 per month, or about \$28,000 annually, equal to about 70 percent of total premiums. For 4 of these applications, we used Social Security numbers that could not have been issued by the Social Security Administration.²⁹ For 4 other applications, we said our fictitious applicants worked at a company—which we also created—that offered health insurance, but the coverage did not provide required minimum essential coverage under PPACA. For the final 2 applications, we used an identity from our prior undercover testing of the federal Marketplace to apply for coverage concurrently at two state marketplaces.³⁰ Thus, this fictitious applicant received subsidized qualified health-plan coverage from the federal Marketplace and the two selected state marketplaces at the same time.

For 8 applications among this group of 10, we failed to clear an identity-checking step during the “front end” of the application process, and thus could not complete the process.³¹ In these cases, we were directed to contact a contractor that handles identity checking. The contractor was unable to resolve the identity issues and directed us to call the appropriate marketplace. We proceeded to phone the marketplaces and

²⁸To receive advance payment of the premium tax credit (described earlier), applicants agree they will file a tax return for the coverage year, and must indicate they understand that the premium tax credits paid in advance are subject to reconciliation on their federal tax return, based on actual income earned. Cost-sharing reduction is a discount that lowers the amount consumers pay for out-of-pocket charges for deductibles, coinsurance, and copayments.

²⁹As noted earlier, the Social Security Administration does not issue Social Security numbers with certain strings of digits.

³⁰See GAO-15-702T.

³¹Known as “identity proofing,” the process uses personal and financial history on file with a credit-reporting agency. The marketplace generates questions that only the applicant is believed likely to know. According to CMS, the purpose of identity proofing is to prevent someone from creating an account and applying for health coverage based on someone else’s identity and without their knowledge. Although intended to counter such identity theft involving others, identity proofing thus also serves as an enrollment control for those applying online.

our applications were subsequently approved. The other two applicants were accepted by phone.³²

For each of the 10 undercover applications where we obtained qualified health-plan coverage, the respective marketplace directed that our applicants submit supplementary documentation. The marketplaces are required to seek postapproval documentation in the case of certain application "inconsistencies"—instances in which information an applicant has provided does not match information contained in data sources that the marketplace uses for eligibility verification at the time of application, or such information is not available. If there is an application inconsistency, the marketplace is to determine eligibility using the applicant's attestations and ensure that subsidies are provided on behalf of the applicant, if qualified to receive them, while the inconsistency is being resolved using "back-end" controls. Under these controls, applicants will be asked to provide additional information or documentation for the marketplaces to review in order to resolve the inconsistency.

As part of our testing, and to respond to the marketplace directives, we provided counterfeit follow-up documentation, such as fictitious Social Security cards with impossible Social Security numbers, for all 10 undercover applications.³³

For all 10 of these undercover applications, we maintained subsidized coverage beyond the period during which applicants may file supporting documentation to resolve inconsistencies. In one case, the Kentucky marketplace questioned the validity of the Social Security number our applicant provided, which was an impossible Social Security number. In fact, the marketplace told us the Social Security Administration reported that the number was not valid. Despite this, however, the Kentucky marketplace notified our fictitious applicant that the applicant was found eligible for coverage. For the four fictitious applicants who claimed their employer did not provide minimum essential coverage, the marketplace

³²We were not required to go through the contractor identity proofing for the two phone applications through the federal Marketplace. All phone and online applications to the state marketplaces, and the online applications to the federal Marketplace, did require the contractor identity proofing.

³³CMS officials said provision of a Social Security number is not a condition of eligibility, but we note the number is nevertheless important for identity verification and tax reconciliation.

did not contact our fictitious employer to confirm the applicant's account that the company offers only substandard coverage.

In August 2015, we briefed CMS and California and Kentucky state officials on the results of our undercover testing, to obtain their views. According to these officials, the marketplaces only inspect for documents that have obviously been altered. Thus, if the documentation submitted does not appear to have any obvious alterations, it would not be questioned for authenticity. In addition, according to Kentucky officials, in the case of the impossible Social Security number, the identity-proofing process functioned correctly, but a marketplace worker bypassed identity-proofing steps that would have required a manual verification of the fictitious Social Security card we submitted. The officials told us they plan to provide training on how to conduct manual verifications to prevent this in the future.

As for our employer-sponsored coverage testing, CMS and California officials told us that during the 2015 enrollment period, the marketplaces accepted applicants' attestation on lack of minimum essential coverage. As a result, the marketplaces were not required to communicate with the applicant's employer to confirm whether the attestation is valid. Kentucky officials told us that applicant-provided information is entered into its system to determine whether the applicant's claimed plan meets minimum essential coverage standards. If an applicant receives a qualified health-plan subsidy because the applicant's employer-sponsored plan does not meet the guidelines, the Kentucky marketplace sends a notice to the employer asking it to verify the applicant information. The officials told us the employer letter details, among other things, the applicant-provided information and minimum essential coverage standards. However, our fictitious company did not receive such notification.

CMS, California, and Kentucky officials also told us there is no current process to identify individuals with multiple enrollments through different marketplaces. CMS officials told us it was unlikely an individual would seek to obtain subsidized qualified health-plan coverage in multiple states. We conducted this portion of our testing, however, to evaluate whether such a situation, such as a stolen identity, would be possible. CMS officials told us the agency would need to look at the risk associated with multiple coverage.

Kentucky officials told us that in response to our findings, call center staff have been retrained on identity-proofing processes, and that they are

improving training for other staff as well. They also said they plan changes before the next open-enrollment period so that call center representatives cannot bypass identity-proofing steps, as occurred with our applications. Further, they said they plan to improve the process for handling of applications where employer-sponsored coverage is at issue. Also in response to our findings, California officials said they are developing process improvements and system modifications to address the issues we raised, and would share details later.

Finally, in the case of the federal Marketplace in particular, for which, as noted, we conducted undercover testing previously, we asked CMS officials for their views on our second-year results compared to the first year. They told us the eligibility and enrollment system is generally performing as designed. According to the officials, a key feature of the system, when applicant information cannot immediately be verified, is whether proper inconsistencies are generated, in order that they can be addressed later, after eligibility is granted at time of application. Earlier, CMS officials told us the overall approach is that CMS must balance consumers' ability to effectively and efficiently select Marketplace coverage with program-integrity concerns.

Preliminary Results of Undercover Attempts to Obtain Medicaid Coverage through the Federal Marketplace and Selected State Marketplaces

In addition to our applications for subsidized private health plans, we also made eight additional fictitious applications for Medicaid coverage in order to test the ability to apply for that program through the marketplaces. As shown in figure 2, in these tests, we were approved for subsidized health-care coverage for seven of the eight applications. For three of the eight applications, we were approved for Medicaid, as originally sought. For four of the eight applications, we did not obtain Medicaid approval, but instead were subsequently approved for subsidized qualified health-plan coverage.³⁴ The monthly amount of the advance premium tax credit for these four applicants totaled approximately \$1,100 per month, or about \$13,000 annually.³⁵ For one of

³⁴Thus, while we did not obtain Medicaid coverage as initially sought, we nevertheless obtained federally subsidized coverage instead.

³⁵Thus, our total advance premium tax credit subsidies received—for the qualified health-plan applications described earlier and the initial Medicaid applications described here that ultimately produced qualified health-plan coverage—totaled approximately \$3,400 per month, or about \$41,000 annually.

the eight applications, we could not obtain Medicaid coverage because we declined to provide a Social Security number.

Figure 2: Summary of Outcomes for Eight Fictitious Applications for Medicaid Coverage

Marketplace	State	Initial application type	Scenario for testing	Obtained Medicaid coverage?
► Federal	New Jersey	☎ Phone	Did not provide Social Security number	Obtained subsidized qualified health-plan coverage in lieu of Medicaid
		💻 Online	Invalid Social Security identity	Obtained subsidized qualified health-plan coverage in lieu of Medicaid
	North Dakota	☎ Phone	Did not have Social Security number; provided impossible immigration document number	Obtained subsidized qualified health-plan coverage in lieu of Medicaid
		💻 Online	Invalid Social Security identity	✓ Yes
► State	California	☎ Phone	Did not provide Social Security number	✗ Application denied
		💻 Online	Invalid Social Security identity	✓ Yes
	Kentucky	☎ Phone	Did not have Social Security number; provided impossible immigration document number	Obtained subsidized qualified health-plan coverage in lieu of Medicaid
		💻 Online	Invalid Social Security identity	✓ Yes

Source: GAO. | GAO-16-136T

As with our applications for qualified health plans described earlier, we also failed to clear an identity-checking step for six of eight Medicaid applications.³⁶ In these cases, we were likewise directed to contact a contractor that handles identity checking. The contractor was unable to resolve the identity issues and directed us to call the appropriate marketplace. We proceeded to phone the marketplaces. However, as shown in figure 2, the California marketplace did not continue to process one of our Medicaid applications. In this case, our fictitious phone applicant declined to provide what was a valid Social Security number, citing privacy concerns. A marketplace representative told us that, to apply, the applicant must provide a Social Security number. The representative suggested that as an alternative, we could apply for Medicaid in person with the local county office or a certified enrollment counselor.³⁷

After we discussed the results of our undercover testing with California officials, they told us their system requires applicants to provide either a Social Security number or an individual taxpayer-identification number to process an application. As a result, because our fictitious applicant declined to provide a Social Security number, our application could not be processed.

Details of Medicaid Applications through the Federal Marketplace

For the four Medicaid applications submitted to the federal Marketplace, we were told that we may be eligible for Medicaid but that the respective Medicaid state offices might require more information. For three of the four applications, federal Marketplace representatives told us we would be contacted by the Medicaid state offices within 30 days. However, the Medicaid offices did not notify us within 30 days for any of the applications. As a result, we subsequently contacted the state Medicaid

³⁶We were not required to go through identity proofing for the two phone applications that went through the federal Marketplace. All phone and online applications from the state marketplaces and the online applications from the federal Marketplace required identity proofing.

³⁷Because this was outside the scope of our review of the marketplaces, we did not follow this avenue.

offices and the federal Marketplace to follow up on the status of our applications.

For the two New Jersey Medicaid applications, we periodically called the state Medicaid offices over approximately 4 months, attempting to determine the status of our applications. In these calls, New Jersey representatives generally told us they had not yet received Medicaid information from the federal Marketplace and, on several occasions, said they expected to receive it shortly. After our calls to New Jersey Medicaid offices, we phoned the federal Marketplace to determine the status of our Medicaid applications.

- In one case, the federal Marketplace representative told us New Jersey determined that our applicant did not qualify for Medicaid.³⁸ As a result, the phone representative stated that we were then eligible for qualified health-plan coverage. We subsequently applied for coverage and were approved for an advance premium tax credit plus the cost-sharing reduction subsidy.
- In the other case, the federal Marketplace representative told us the Marketplace system did not indicate whether New Jersey received the application or processed it. The representative advised we phone the New Jersey Medicaid agency. Later on that same day, we phoned the federal Marketplace again and falsely claimed that the New Jersey Medicaid office denied our Medicaid application. Based on this claim, the representative said we were eligible for qualified health-plan coverage. We subsequently applied for coverage and were approved for an advance premium tax credit plus the cost-sharing reduction subsidy. The federal Marketplace did not ask us to submit documentation substantiating our Medicaid denial from New Jersey.

We asked to meet with New Jersey Medicaid officials to discuss the results of our testing, but they declined our request. CMS officials told us that New Jersey had system issues that may have accounted for problems in our Medicaid application information being sent to the state. CMS officials told us that this system issue is now resolved. In addition, CMS officials told us they do not require proof of a Medicaid denial when processing qualified health-plan applications; nor does the federal

³⁸Earlier that day, in a phone call with the New Jersey Medicaid agency, a representative said—contrary to the federal Marketplace statement—that the agency had not received application information from the federal Marketplace.

Marketplace verify the Medicaid denial with the state. CMS officials said that instead, they accept the applicant's attestation that the applicant was denied Medicaid coverage.

For our North Dakota Medicaid application in which we did not provide a Social Security number but did provide an impossible immigration document number, we called the North Dakota Medicaid agency to determine the status of our application. An agency representative told us the federal Marketplace denied our Medicaid application and therefore did not forward the Medicaid application file to North Dakota for a Medicaid eligibility determination.³⁹ We did not receive notification of denial from the federal Marketplace. Subsequently, we called the federal Marketplace and applied for subsidized qualified health-plan coverage. The federal Marketplace approved the application, granting an advance premium tax credit plus the cost-sharing reduction subsidy. Because we did not disclose the specific identities of our fictitious applicants, CMS officials could not explain why the federal Marketplace originally said our application may be eligible for Medicaid but subsequently notified North Dakota that it was denied.

For the North Dakota Medicaid application for which we did not provide a valid Social Security identity, we received a letter from the state Medicaid agency about a month after we applied through the federal Marketplace. The letter requested that we provide documentation to prove citizenship, such as a birth certificate. In addition, it requested a Social Security card and income documentation. We submitted the requested documentation, such as a fictitious birth certificate and Social Security card. The North Dakota Medicaid agency subsequently approved our Medicaid application and enrolled us in a Medicaid plan.

After our undercover testing, we briefed North Dakota Medicaid officials and obtained their views. They told us the agency likely approved the Medicaid application because our fake Social Security card would have cleared the Social Security number inconsistency. The officials told us they accept documentation that appears authentic. They also said the agency is planning to implement a new system to help identify when

³⁹As noted earlier, the federal Marketplace representative stated that our application may be eligible for Medicaid but more information may be needed by the Medicaid state offices.

applicant-reported information does not match Social Security Administration records.

Details of Medicaid Applications through State Marketplaces

As with our applications for coverage under qualified health plans, described earlier, the state marketplace for Kentucky directed two of our Medicaid applicants to submit supplementary documentation. As part of our testing and in response to such requests, we provided counterfeit follow-up documentation, such as a fake immigration card with an impossible numbering scheme for these applicants. The results of the documentation submission are as follows:

- For the application where the fictitious identity did not match Social Security records, the Kentucky agency approved our application for Medicaid coverage. In our discussions with Kentucky officials, they told us they accept documentation submitted—for example copies of Social Security cards—unless there are obvious alterations.
- For the Medicaid application without a Social Security number and with an impossible immigration number, the Kentucky state agency denied our Medicaid application. A Kentucky representative told us the reason for the denial was that our fictitious applicant had not been a resident for 5 years, according to our fictitious immigration card. The representative told us we were eligible for qualified health-plan coverage. We applied for such coverage and were approved for an advance premium tax credit and the cost-sharing reduction subsidy. In later discussions with Kentucky officials, they told us the representative made use of an override capability, likely based on what the officials described as a history of inaccurate applicant immigration status information for a refugee population. Kentucky officials also said their staff accept documentation submitted unless there are obvious alterations, and thus are not trained to identify impossible immigration numbers. Finally, Kentucky officials said they would like to have a contact at the Department of Homeland Security with whom they can work to resolve immigration-related inconsistencies, similar to a contact that they have at the Social Security Administration to resolve Social Security-related inconsistencies.

By contrast, during the Medicaid application process for one applicant, California did not direct that we submit any documentation. In this case, our fictitious applicant was approved over the phone even though the fictitious identity did not match Social Security records. We shared this result with California officials, who said they could not comment on the

specifics of our case without knowing details of our undercover application.

As noted earlier, the findings discussed in this statement are preliminary, and we plan to issue a final report later, upon completion of our work.

Chairman Pitts, Ranking Member Green, and Members of the subcommittee, this concludes my statement. I look forward to the subcommittee's questions.

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Mr. PITTS. The chair thanks the gentleman. Thanks to both of you for your testimony.

We will begin the questioning. I will recognize myself 5 minutes for that purpose.

And this question is for both of you. I will start with you, Ms. Yocom. Today, we are just over a week away from the start of open enrollment for exchange coverage under the Affordable Care Act. Do you have any reason to believe that the vulnerabilities identified by GAO and reported in your testimony have been sufficiently addressed by CMS, or are these program gaps in vulnerabilities ongoing?

Ms. YOCOM. There certainly are remaining concerns about the need for better oversight of the eligibility determination process, and also checking to ensure that the appropriate matching rate is or has been used. CMS has taken some actions over the course of the summer, but there is more to do.

Mr. PITTS. Mr. Bagdoyan.

Mr. BAGDOYAN. Yes. Thank you, Mr. Chairman.

I would echo what Ms. Yocom said in terms of questions and concerns that remain. As I mentioned in my opening statement, we have not detected any change in the CMS control environment, which is the broad set of controls from the front, the middle, and the end. In fact, for the end control, which is essentially the tax reconciliation process, there have been several reports from the Treasury inspector general for tax administration, the HHS, OIG, as well as GAO itself, questioning the capability of CMS and the IRS to effectively implement that control. So my answer would be the vulnerabilities remain based on the evidence that we have.

Mr. PITTS. When did GAO first make CMS aware of the vulnerabilities identified? For example, in the undercover work specifically, hasn't CMS known about these problems since at least last summer?

Ms. Yocom, or Mr. Bagdoyan?

Mr. BAGDOYAN. Yes, thank you. Yes, we had a hearing before the House Ways and Means Committee in July of 2014, and we discussed our initial look at the time for coverage year 2014 with CMS in detail. And so they were aware, at least, of the very specific issues that we raised, in terms of control vulnerabilities.

Mr. PITTS. Let's continue, Mr. Bagdoyan. During the first 2 years, GAO has successfully obtained federally-funded, or subsidized coverage, for 28 of 30 of the fictitious applicants, each of which should have been denied coverage because they did not have or provide sufficient evidence of eligibility according to your testimony. That is a 93 percent error rate. Does GAO find that acceptable? Is there any other Federal Government program with even near as high an error rate?

Mr. BAGDOYAN. Well, I would certainly caution the use of that 93 percent. Certainly, the sample we used was not generalizable. It was designed to raise concerns and flags about specific controls. As you know, the issue of improper payments was discussed by the comptroller general recently. The trend is up after several years of some modest decline. So that is the environment we are looking at, this issue overall. We are not trying to specifically target any one individual for their health coverage. As I mentioned in my opening

statement, we have parallel forensic audit work ongoing right now, and that is looking at each and every enrollee in the system, and we would be subjecting those enrollee databases to various types of analyses.

Mr. PITTS. Now, supporters of the Affordable Care Act like to claim—or they are likely to claim that GAO’s fictitious applications do not represent actual fraud, and question whether GAO has identified any real fraud. It is my understanding that GAO’s undercover work was also supposed to be paired with a forensic audit of actual exchange enrollment data, but that CMS has stonewalled GAO in providing the data necessary to do that work. Can you please describe the delays GAO has experienced in obtaining the necessary data from CMS?

Mr. BAGDOYAN. Sure. Yes. First, just to restate the fact that the work we did undercover was not designed to detect fraud, per se, in the general population. Although when we did perform the work, we obviously engaged in fraudulent activity, which is consistent with our investigative authority for these purposes. And, yes, we do have ongoing forensic audits for coverage year 2014. In discussions with staff, we are ready to request 2015 information for coverage year 2015 or other—

Mr. PITTS. And could you just briefly—

Mr. BAGDOYAN. Yes, I will mention that our initial contact with CMS to obtain the 2014 data began in April of last year, and it was not resolved until recently this year. So it took about a year of negotiation to obtain that data set.

Mr. PITTS. OK. My time has expired. I recognize the ranking member, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman. I thank the witnesses for your testimony today.

Mr. Bagdoyan, I want to ask some of the results, your preliminary results of your work on the eligibility of enrollment, and hopefully, because I have a lot of questions, we can get yes or no.

First of all, how many fictitious identifies did GAO create and attempted to get the coverage from Medicaid or subsidized marketplace coverage?

Mr. BAGDOYAN. For coverage year 2015, which is the work I am testifying on today, there were 18 separate applications.

Mr. GREEN. OK. How many of these applications were made online?

Mr. BAGDOYAN. I think most of them actually, began online, and then switched to phone application as we encountered the identity proofing restriction.

Mr. GREEN. So all 18 started online?

Mr. BAGDOYAN. Most of them did.

Mr. GREEN. OK. How many of the applicants failed on ID proofing? How many of these applications failed on ID proofing?

Mr. BAGDOYAN. I would say the vast majority of them failed the online ID proofing step.

Mr. GREEN. According to your testimony, ID proofing, “served as an enrollment control for those applying online,” is that correct?

Mr. BAGDOYAN. That is correct.

Mr. GREEN. And let's see if I understand correctly. Each of these applicants were directed to phone the marketplace and reply by phone, correct?

Mr. BAGDOYAN. We were directed to call the contractor, Experian, who is tasked with performing the identity proofing. When they also could not proof for identity, they directed us to call the marketplaces, and that is what we did, and we considered that a control workaround.

Mr. GREEN. Were these applicants informed over the phone that there were civil or criminal penalties for providing inaccurate, untruthful information to the exchange?

Mr. BAGDOYAN. As I recall, the representatives did read them statements to that effect, yes.

Mr. GREEN. And are you aware that in addition to criminal penalties for perjury, there are significant civil penalties in the statute for negligent or knowingly reporting false information to the exchanges?

Mr. BAGDOYAN. Yes, I am aware of that.

Mr. GREEN. And if I understand your testimony, each of the 18 applications, all of them resulted in inconsistency?

Mr. BAGDOYAN. The ones that we were successful, which were 17 of 18, most of those resulted in some sort of inconsistency which needed to be cleared, yes.

Mr. GREEN. And according to your testimony, if there is an inconsistency, the marketplace determines eligibility using the applicant's attestations and then requires applicants to provide additional documentation to resolve the inconsistency? Is that correct?

Mr. BAGDOYAN. That is correct.

Mr. GREEN. And this is another control in the eligibility enrollment process?

Mr. BAGDOYAN. Well, the submission of documentation, we consider that to be more of a middle control. I think the whole system essentially relies on self-attestation, which is a concern itself in an overall control environment.

Mr. GREEN. And GAO submitted forged documentation for each of these applications for coverage?

Mr. BAGDOYAN. That is correct.

Mr. GREEN. So, for instance, fake Social Security cards, fake driver's license, fake immigration documents, and so forth?

Mr. BAGDOYAN. That is right.

Mr. GREEN. OK. Are you aware that there are significant criminal and civil penalties under both state and Federal law for creating and using falsified documentation, such as driver's license and Federal immigration documents?

Mr. BAGDOYAN. Yes, I am.

Mr. GREEN. Did GAO, at any time, contact the Office of Inspector General for Health and Human Services?

Mr. BAGDOYAN. We coordinate our work upfront with them, but we don't discuss any of our investigative details.

Mr. GREEN. OK. Has this report been submitted to the Office of Inspector General?

Mr. BAGDOYAN. No, it has not.

Mr. GREEN. I want to thank you for your testimony. It makes clear that there are multiple layers of eligibility enrollment con-

trols in the state and Federal marketplaces. While there is always room for improvement, I take issue with assertions of some of my colleagues that we have an ideological opposition to the ACA to seek to falsify, portray the eligibility enrollment system. I think there are some safeguards in it, but, again, we have a lot of different groups that can investigate that, including the inspector general for the Health and Human Services.

Mr. Chairman, I yield back my time.

Mr. PITTS. The chair thanks the gentleman, now recognize the vice chairman of the full committee, Mrs. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And just as a point of clarification, as we are having this discussion, I think that it is important to note that having secret shopper programs are standard operating procedures for businesses that work in the consumer realm that are in customer service. Secret shopper programs are used by restaurants, by hotels, by retail establishments. They are used by our chambers of commerce many times.

So to say it is fake, or that it is something that is unseemly and stealth, I think it is important to note that this is how many organizations go in and do a spot check on how they are performing and how they are delivering a service.

As I said, coming from the state where we have had a little bit of a history with this through Medicaid expansion, I appreciate the attentiveness to the detail of trying to make certain there are fewer vulnerabilities within the system where people can come in, fake their eligibility, enroll, and then get services that the taxpayers are paying for, services to which they are not entitled, and their utilization of those services means there is less for those who actually need and deserve and qualify for those services.

Mr. BAGDOYAN, I want to start with you and go back to this vulnerability where you say that the documentation submitted does not appear to have any obvious alterations, it would not be questioned in its authenticity. That seems like a very low bar to me.

So did fabricating the documentation requested as part of the application process require specialized knowledge or any great technical skill?

Mr. BAGDOYAN. Not really.

Mrs. BLACKBURN. So this is something that anybody could do from a simple home computer or a keyboard?

Mr. BAGDOYAN. Yes. We used commercially available computers, software, and paper materials. You just have to have a basic knowledge of what these things look like, and those are readily available from the Internet.

Mrs. BLACKBURN. So in replicating the marketplace in order to do your research, you used as many different points of entry as options to enter the system?

Mr. BAGDOYAN. Yes. We had no foreknowledge of what the controls were that we would encounter. And that goes back to our 2014 work. We went, behaving as a typical consumer would, encountering the program and the systems it has for the first time.

Mrs. BLACKBURN. And that is how any smart businessperson would do an evaluation of the vulnerabilities and the risks embed-

ded in their system, and ascertain as to whether or not the proper controls are in place to prevent any type of fraud or leakage.

Let me ask you this: How would you respond to claims that the risk of fraud is low, because subsidies are provided directly to the insurer as opposed to the enrollees?

Mr. BAGDOYAN. Right. Thank you for your question. In that regard, we view the subsidy issue as still being beneficial, financially, to an applicant. Essentially, it keeps more money in their pocket when they pay the premiums, or if they choose to take the subsidy in the form of a tax credit, that reduces their tax liability, or it could also result in a refund, which does involve getting a check from the government.

Mrs. BLACKBURN. OK. Thank you.

Ms. Yocom, just one question before we move on. The 100 percent Federal funding for the newly eligible, the states obviously have a financial incentive to bulk up that enrollment. And what, if any, safeguards did CMS institute to ensure that taxpayers were not paying more than their share of the state's Medicaid program?

Ms. YOCOM. The primary safeguard that CMS has been using has been the eligibility reviews that they have conducted. They have asked, first, for states to take samples of applications and review them, and then they have reviewed the results of those applications.

Mrs. BLACKBURN. So the states are following through on the verification?

Ms. YOCOM. When errors or problems are identified, then the states need to file a corrective action plan with CMS that says how they will correct those errors.

Mrs. BLACKBURN. Very good. Thank you.

I yield back.

Mr. PITTS. The chair thanks the gentlelady, now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes of questions.

Mr. PALLONE. Thank you, Mr. Chairman.

My questions are for Mr. Bagdoyan. I want you to understand, Mr. Bagdoyan, why I am so critical of this fake shopper investigation. I just feel that it is very important for people to get health insurance. And I know that the GAO is spending a lot of money doing this investigation, and it just seems to me that it is not a priority. My colleagues on the Republican side every year try to cut funding for the IRS. And you would think that the people that are cheating the income tax would be the ones you would be most concerned about defrauding the government, but they keep cutting the enforcement dollars for that. So it is always a question of priorities.

Who is it that asked you to do this fake shopper investigation?

Mr. BAGDOYAN. Yes. As we reflect in my statement, Mr. Pallone, this request originated with the Senate Finance Committee, the House Committee on Ways and Means, and the House Committee on Energy and Commerce.

Mr. PALLONE. The majority?

Mr. BAGDOYAN. The majority.

Mr. PALLONE. OK. And why did you decide that this was a priority? In other words, I know a lot of times in Congress committees

ask GAO to do investigations, they don't do it. Why did you think this was a priority?

Mr. BAGDOYAN. Well, actually, we do respond to each and every request.

Mr. PALLONE. You respond, but you don't necessarily do it.

Mr. BAGDOYAN. We prioritize them. And when the term of this engagement came, it was fully staffed, and the work began.

Mr. PALLONE. So you just basically do every investigation that any congressional committee asks you to do?

Mr. BAGDOYAN. For the most part, yes.

Mr. PALLONE. Well, I haven't found that to be true.

Let me ask you this: You are a government employee, right?

Mr. BAGDOYAN. That is correct.

Mr. PALLONE. And how do you get your health insurance?

Mr. BAGDOYAN. Through the government, through the GAO.

Mr. PALLONE. Well, not through the GAO, but through the Federal employee program, right?

Mr. BAGDOYAN. Right.

Mr. PALLONE. Why did you decide to investigate the exchange marketplaces and not the Federal employee program? Why didn't you set up fake shoppers for that?

Mr. BAGDOYAN. Well, that was not my decision. It is a response to a request from Congress; we do our best to respond to that. And we operate for this work under the premise that this is the law on the books, and our work is to make sure that it gets done as intended.

Mr. PALLONE. I understand that. But I also understand that in order to obtain coverage fraudulently, one would need to be extremely motivated, willing to break a number of different laws with serious civil and criminal penalties for no direct financial gain, and I think that is highly unlikely. And if an enrollee did manage to do all that, they would still have to pay their share of premiums before their coverage is effective, and you never even went so far as to ask for their income taxes, which is the final check.

So I just think that when you make decisions about what you are going to prioritize and investigate, you have got to think about what the consequences are. You are spending taxpayer dollars, and whether or not there is any legitimate reason to do this. Have you examined the incidents of fraudulent documentation being used in the marketplaces? In other words, how big a problem this is in reality? Is that something you have looked at as to what extent this is a real problem?

Mr. BAGDOYAN. Sure. Thank you for that question. As I mentioned earlier in response to another question along those lines, we have parallel forensic audit work that is looking at all the enrollees from coverage year 2014, and we are in the process of requesting coverage year 2015 data, and we will subject those data sets to various sorts of analysis.

Mr. PALLONE. But to this date, we have no information to tell us how big this problem is?

Mr. BAGDOYAN. That is correct, yes.

Mr. PALLONE. OK. All right. I just think that it is important when—it just disturbs me a great deal to think that what you are basically telling me is that anything Congress asks you to do, no

matter how spurious it might be, no matter whether or not you think it is important or not, you are just going to do it because Congress asked you to do it. I mean, if that were the case, there would be no real-world applicability to what you do. And it is shocking to me to think that every time someone went up and there was a check in the marketplace for someone who was trying to be fraudulent, you had to go and make another false identity each time. And then, finally, when you got to the point where they would have to submit their tax returns, you didn't even bother to do that, which probably would have been the ultimate check.

Why didn't you ask for the tax returns? Why didn't you go to that ultimate check?

Mr. BAGDOYAN. This part of the work was designed to take our checks or control reviews to the middle part of the controls, which essentially ends with the document verification.

Mr. PALLONE. So, in other words, is it possible you just thought that one would be too difficult for people to accomplish?

Mr. BAGDOYAN. No, not at all.

Mr. PALLONE. Well, so it is just because you didn't have the time basically? You did the middle part but not the end result?

Mr. BAGDOYAN. Each plan stands on its own merit, Mr. Pallone.

Mr. PALLONE. It doesn't have any merit in my opinion, Mr. Bagdoyan. I am shocked. It seems to me that something has to be done about the way GAO proceeds, if they just do these things and we have no accountability as to whether it accomplishes anything or is useful in the real world. Thank you.

Mr. BAGDOYAN. Thank you.

Mr. PITTS. The chair thanks the gentleman, now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you. Thank you, Mr. Chairman.

Thanks for being here. It is good to follow my friend, the ranking member, because the history is also instructive. The healthcare law was passed, especially the sidecar, with no debate through the committee, no oversight hearings, and really, no debate on the floor.

So that is why we on our side, continue to look and try to do our oversight. When we were still in the minority, we asked for hearings on how the healthcare law would work; we asked for hearings on the rollout; we asked for hearings on the eligibility standards; we asked for hearings on fraud; we asked for hearings on Medicaid expansion. We never had any receptivity to any oversight hearings when we were in the minority. So now that we are doing oversight when we are on the majority, I am not sure why people should be surprised at that. So now I will go to my questions.

For Mr. Bagdoyan, it is my understanding that CMS asked GAO to provide identifying information about its fictitious applicants; is that correct?

Mr. BAGDOYAN. That is correct.

Mr. SHIMKUS. Has GAO provided such information to other agencies in which similar undercover work has been performed?

Mr. BAGDOYAN. Not to my knowledge.

Mr. SHIMKUS. What would be the implications of providing the identities of the fictitious applicants on GAO's ability to conduct future undercover work, whether on the ACA or any Federal program?

Mr. BAGDOYAN. Yes, it would essentially compromise our sources, methods, and techniques. A lot of this information is directly connected to the agents who performed the work, so it would expose them to risk, such as identity theft, and overall, it could compromise our ability to conduct investigations for the current Congress, future Congresses. So those are significant implications.

GAO has been doing this for over 30 years, and it is a long-standing capability that we offer, and we pursue them according to the applicable investigative standards.

Mr. SHIMKUS. And your profession, I guess the frustration is—we are actually on the same team, and we have got a law. We want it to be applicable in a responsible manner. You have a role to help us do that. When I was in the Army and we had the IG coming down—they are here to help us. They were a pain in the rear end, but they were just to help ensure that we had our procedures and our performance standards in line with the expectations of the command guidance in the Army. So no one likes to have people go through their dirty laundry, I get it. But that is your job, and we appreciate it.

Some of my colleagues on the other side of the aisle may question the utility of your findings because of the results of 18 fictitious applicants are not generalizable. In fact, you used that term earlier to another question. I understand that GAO's methodology was not intended to provide generalizable results; is that correct?

Mr. BAGDOYAN. Yes, that is correct, Mr. Shimkus.

Mr. SHIMKUS. And what was GAO's methodology designed to show? And given the results, what has GAO concluded?

Mr. BAGDOYAN. Yes. The methodology, as with 2014 and with 2015, was designed specifically to flag potential control vulnerabilities. And in each case, we detected those vulnerabilities, and as I mentioned earlier, we have a separate report that will be coming out within the near future that will be directed to all the requesters with recommendations, specifically to CMS, and we have discussed those already at a general level with CMS, including the acting administrator.

Mr. SHIMKUS. Great. Thank you.

And for Ms. Yocom, do you find it concerning that at a time when states are implementing significant changes to the Medicaid eligibility determination process, and the Federal Government, for the first time, is determining Medicaid eligibility in some states, CMS decided to suspend its measurement of the eligibility component of its payment error rate measurement program?

Ms. YOCOM. We are concerned about that. The eligibility determination rate is not going to be based on the Affordable Care Act and the eligibility actions therein. And at this point, I believe the latest information is that it will not be until 2019 before the error rate is actually applied. CMS is doing eligibility reviews, and it is important to do this. We do want them to be a little more transparent about what they are finding and how they are fixing it.

Mr. SHIMKUS. Thank you, Mr. Chairman. I yield back my time. Thank you for coming.

Mr. PITTS. The chair thanks the gentleman, now recognize the gentlelady from California, Mrs. Capps, for 5 minutes of questions.

Mrs. CAPPS. Thank you, Mr. Chairman. I am going to yield a few seconds to my ranking member.

Mr. GREEN. Mr. Chairman and my colleague and good friend from Illinois, you were on the committee when we had exhaustive hearings in drafting the Affordable Care Act. In fact, I remember some very all-nighters, it seemed like. So our committee did do its due diligence in 2009 and 2010, as I recall, because I was on the committee in 2003, when we expanded the prescription drug plan.

Mr. SHIMKUS. Will the gentleman yield?

Mr. GREEN. It is not my time.

Mrs. CAPPS. It is my time. Certainly.

Mr. SHIMKUS. I would ask the public to check the record. I will stand by my statement.

Mrs. CAPPS. Thank you again, Mr. Chairman. As some of my colleagues have pointed out, the forensic work that GAO is providing testimony on today is interesting, unfortunately, not particularly applicable to the real world. It's highly unlikely that people would use fraudulent identities to enroll in a qualified health plan. The number of hurdles they would have to overcome in order to get coverage, not to mention the number of state and Federal laws they would have to break simply are not realistic for someone who is just trying to apply for health coverage, health coverage that they are going to pay for with their own premium dollars, by the way, with any subsidies going not to them, but to their insurance company.

In sharp contrast to GAO, the work of the HHS Office of Inspector General has been doing to review real-life cases have been far more constructive than finding areas where both the Federal- and the state-based marketplaces can improve their eligibility and their enrollment processes. For example, the Office of Inspector General just released a report on Kentucky State-based marketplace, and reviewed a sample of 45 actual case files and reviewed staff and contractors and reviewed documents.

Mr. Bagdoyan, are you aware of this report? Yes or no?

Mr. BAGDOYAN. Yes, I am.

Mrs. CAPPS. Thank you. The OIG report found that the states' controls were generally sufficient but did find some issues that occurred primarily due to system errors, such as failing to send a notice of inconsistency, flagging that something is not right. The State has corrected these errors by addressing the problem with the system and also made sure that the people and the cases with errors were actually eligible, which, in fact, they were, despite the system errors.

Similarly, a review of the federally-run marketplace in August found some issues in how it resolves inconsistency. As in Kentucky, CMS confirmed that people in the cases with problems are actually eligible, and is making changes to improve the process of resolving inconsistency. The OIG provides specific information on the errors they find so they can be corrected, or otherwise remedied.

Mr. Bagdoyan, do you plan to make the identifying information for the fictitious applications available to CMS and to the state-based marketplace in order that these entities address the root causes of the errors, yes or no?

Mr. BAGDOYAN. As with our past position, we will not be providing that information.

Mrs. CAPPS. Why not?

Mr. BAGDOYAN. Because it involves investigative techniques, sources, and methods, undercover identities that are directly linked to our agents who would then be exposed to risk.

Mrs. CAPPS. Well, I find this important. And I must say I think this further supports what I have been saying about the real-world applicability of GAO's forensic work in this case, by looking at actual cases rather than wholly artificial ones, the OIG is identifying where there are actual real-life problems, and the eligibility enrollment system that needs to be corrected. And their investigation gives states like California where I live, and the Federal Government, the opportunity to actually improve the way the systems work, and this benefits consumers and taxpayers.

In contrast, GAO's work looks at theoretical problems involving fictitious applicants who do not actually operate as people, operate in the real world, and then refuses to provide information sufficient for these agencies to make genuine system improvements.

One last question, Mr. Bagdoyan. You said that the documents forged and produced were deemed with readily available materials, how much money did you need to spend on these materials for computers, printers or other internals?

Mr. BAGDOYAN. Very little to none. They are readily available to us as part of our investigative capability.

Mrs. CAPPS. How much time did you spend on this project?

Mr. BAGDOYAN. The work has been ongoing since 2014.

Mrs. CAPPS. This isn't an area suitable expectation for—well, I appreciate that information. And again, it is just unfortunate. Thank you very much. I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentlelady. I now recognize the vice chair of the subcommittee, Mr. Guthrie, for 5 minutes for questions.

Mr. GUTHRIE. Thank you very much, we have talked about Kentucky a lot. Kentucky has been talked about a lot in Affordable Care Act, and the one thing that I have always said were on the Affordable Care Act are people working for a state government made a Web site that worked, that actually operated when a lot of places weren't able to do that.

The problem is that in this study that you moved forward, and I understand what Ms. Capps is referring to, but those are people who qualified, and there were just mistakes made on those applications. My understanding is in your fictitious people signing up that weren't qualified for subsidies, and the way you set up the scenario that Kentucky had five out of five get coverage, even though they should not have gotten coverage, so 100 percent.

I know that is not—five cases, but if somebody told me it was two out of five and that is 40 percent, or if it is one out of five and that is 20 percent. But five out of five is 100 percent, so who knows? You can sort of start making some extrapolations as a statistics person even with those few numbers. There is also 17 out of 18, I understand.

And so in your statement, your written statement, Mr. Bagdoyan, you said, and I quote, that CMS told GAO officials, "the

eligibility and enrollment system is generally performing as designed.”

Mr. BAGDOYAN. That is correct.

Mr. GUTHRIE. Working as designed is what they said. What do you make of the statement, given that 93 percent, or 17 out of 18 of your fictitious applicants enrolled in subsidized coverage?

Mr. BAGDOYAN. Well, I would answer that question in the context of what CMS told us in respect of balancing access to coverage with program integrity. So if you look at it that it was designed—it is working as intended, that means that access is enabled. I would say that the overall balance would tilt to access over program integrity at this point in time.

Mr. GUTHRIE. So they are willing to accept that fictitious people can register because it is easier for everybody to register?

Mr. BAGDOYAN. That would be for CMS to respond to.

Mr. GUTHRIE. So in your opening statement, also, you indicated that GAO found no improvements in the federally-facilitated marketplace control environment between plan year 2014 and plan year 2015. When did GAO first share information with CMS about the weaknesses found in the marketplace, eligibility determination controls. And are there changes that CMS could have made between the 2-year plans to address these concerns?

Mr. BAGDOYAN. Sure. We first broached the subject at the conclusion of our first round, if you will, of our undercover work, which would have occurred in early summer of 2014, right before the July hearing, before the House Ways and Means Committee.

Mr. GUTHRIE. OK.

Mr. BAGDOYAN. And in terms of having information from us, we discussed in detail how each scenario unfolded, both in 2014 and 2015. We explained how we worked around the identity proofing control that we encountered, and provided related information that they could have used to notice that the ID proofing workaround was a problem, and also the fact that the documents that we submitted were not really subjected to any kind of scrutiny other than did they really look altered to the naked eye.

Mr. GUTHRIE. OK.

Mr. BAGDOYAN. And I would point out, in terms of providing information to others, that we had discussions with Kentucky officials in person.

Mr. GUTHRIE. It is my understanding they are very receptive to try to change—

Mr. BAGDOYAN. They were receptive. Again, we provided information. We went to Kentucky to discuss those in person. And in response to the statement, those officials let us know that they are already taking action in two areas: One is training of their representatives, and the second one is to improve their system so the ID proofing step or control is not so easily over worked around.

Mr. GUTHRIE. Thank you for pointing that out. I should have pointed that out as well that our State employees were trying to make these improvements.

Mr. BAGDOYAN. That is correct. They have been receptive to our discussions and already taking action. And they promised to provide us with additional details when we finalize this work, this 2015 round of undercover work in a final report.

Mr. GUTHRIE. I appreciate hearing that.

And then for Ms. Yocom, I have one quick question. Ten States have delegated authority to Medicaid eligibility determinations to the Federal Government. What, if anything, has CMS done to access the accuracy of Medicaid eligibility decisions made by the Federal exchanges in determining eligibility error rate?

Ms. YOCOM. When we began our work, the short answer is they had not done anything. Our process is pretty interactive with CMS. They have reported to us that they have begun looking at the FFE, at the Federally Facilitated Exchange, eligibility determinations beginning in August. We do not know the results of those reviews.

Mr. GUTHRIE. OK. So they just began this August and we are waiting to hear?

Ms. YOCOM. Yes.

Mr. GUTHRIE. OK. It would be interesting to hear when that time comes. Well, thank you. I just ran out of time. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from North Carolina, Judge Butterfield for 5 minutes for questions.

Mr. BUTTERFIELD. Thank you, Mr. Chairman, and good morning to both of you. I thank you very much for your testimony. And in the interest of time, I think most of my questions will be directed to the GAO representative, Ms. Yocom, but thank you as well, sir, for your participation.

Mr. BAGDOYAN. You are welcome.

Mr. BUTTERFIELD. Mr. Chairman, I think it is important for us to remember why we have these systems in place in the first place. Democrats on this committee, as you would recall, who drafted the Affordable Care Act, envisioned a no-wrong-door policy in which individuals could apply either at the state Medicaid office, or they could apply through the exchanges and would get an eligibility determination for whichever program they are eligible for.

Ms. Yocom, let's start with this: I would like to ask you some questions about how the ACA implements this no-wrong-door policy and what this really entails?

Ms. YOCOM. Sure. The purpose of the no-wrong-door is that an individual can approach a marketplace, they can approach the state Medicaid agency, they can go on to the Web site and from any of those areas, determine which type of insurance, if any, they are eligible for, and then whether they would get a subsidy in the event they qualified for exchange coverage.

Mr. BUTTERFIELD. That is what I recall. Is it correct, Ms. Yocom, that people can only enroll in a qualified health plan during open enrollment, unless there has been a change in circumstances, such as losing other coverage?

Ms. YOCOM. That is correct.

Mr. GUTHRIE. And coverage on a QHP doesn't start until after the enrollment, and after payment of the first premium. Is that correct?

Ms. YOCOM. That is correct.

Mr. BUTTERFIELD. I am informed that the general rule is that enrollment before the 15th of the month starts coverage in the following month, and enrollment after the 15th results in coverage

starting in the month following the month of enrollment. Is that correct?

Ms. YOCOM. I believe so, yes.

Mr. BUTTERFIELD. Yes, that is my recollection as well. If individuals had to wait to have their attestations verified through review of paper documents, it could result in significant delays in coverage, or they could miss the open enrollment period altogether. Would you agree with that statement?

Ms. YOCOM. Yes, there are delays we have identified as potential scenarios.

Mr. BUTTERFIELD. All right. Moving right along. Under the ACA eligibility to enroll in coverage through a QHP, and to qualify for premium tax credits and cost-sharing reductions is determined on a real-time basis, based on the information individuals attest to on their application, and I might say, under penalty of perjury. Verification occurs in real time using electronic data to the fullest extent possible.

Ms. Yocom, the eligibility determination process, using the electronic data through the Federal data hub, is an important feature of the marketplace that operates to prevent individuals from obtaining fraudulent coverage, coverage that they are not eligible for, and even duplicate coverage. Is that close to being correct?

Ms. YOCOM. Yes, the one thing I would add is that with the Medicaid eligibility determination, the connection between exchange coverage and Medicaid is where the difficulty is and the potential duplication is likely to occur.

Mr. BUTTERFIELD. Do you know of any other system in Federal Government that operates like this in real time and using data sources across the Federal Government?

Ms. YOCOM. I don't, but I am not an expert.

Mr. BUTTERFIELD. When eligibility factors can't be verified immediately using electronic data sources, people must apply paper documents within a set time period to verify their eligibility. Am I correct on that?

Ms. YOCOM. That is correct.

Mr. BUTTERFIELD. Do you agree or disagree that this is another backstop in the process to ensure that individuals are only getting the coverage they are entitled to?

Ms. YOCOM. Yes, getting the documentation as a backup is important, yes.

Mr. BUTTERFIELD. Then would you agree that on the back end, the Federal Government reconciles the premium tax credits to ensure that beneficiaries only get what they are entitled to on the back end?

Ms. YOCOM. That is the hope. We have done some work GAO has that does look at issues with the IRS and the ability to reconcile right now, so—

Mr. BUTTERFIELD. All right. We said in the beginning, years ago when we passed the Affordable Care Act, and we continue to say today, it is not perfect, but we are going to continue until it reaches perfection.

I thank both of you for your testimony. I yield back.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Florida, Mr. Bilirakis, for 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman, I appreciate it very much. And I thank the panel for their testimony.

Mr. Bagdoyan, under Federal law, an individual who has access to affordable minimal essential coverage through their employer is not eligible for the subsidy on the exchange. Based on GAO's work, what are the Federal and State exchanges doing to assess whether an applicant has access to employer-sponsored insurance before providing them a taxpayer-funded subsidy?

Mr. BAGDOYAN. Thank you for your question Mr. Bilirakis. For the scenarios we conducted, I believe there were four of those instances, we did not detect any activity between the exchanges and the employer.

Mr. BILIRAKIS. Thank you. Another question for you, sir. Are you aware of any actions that the Federal and state marketplaces have taken in response to your findings?

Mr. BAGDOYAN. The Federal marketplace has not, to our knowledge. As I mentioned, we detected no changes in the control environment between 2014 and 2015. At least two states we spoke with, as I mentioned to Mr. Guthrie, Kentucky is one of them. They gave specific information as to the actions they are currently taking, as well as the California State exchange. We had an extensive discussion with them, and they provided us with an overview of what they are doing, and plan to do, and they promised us additional details to include in our final report on this—

Mr. BILIRAKIS. Those States have been able to make changes in response to your findings in just a few months, but CMS has not made changes, even though they had more than a year. Is that correct?

Mr. BAGDOYAN. That would be one way to characterize it, yes.

Mr. BILIRAKIS. Thank you. Ms. Yocom, you indicated that States raised concerns about the quality of Medicaid eligibility assessments and determinations made by Federal exchanges. What actions did CMS take to review those assessments and determinations?

Ms. YOCOM. The short answer is at the beginning of our work, CMS had not taken any actions. CMS did, in response to our recommendations, say that they were going to begin conducting reviews of the facilitated exchangeability to determine Medicaid eligibility, and they have conducted reviews in two states so far.

Mr. BILIRAKIS. What types of errors were identified and what were the causes of those errors?

Ms. YOCOM. Most of the errors were related to income verification. There were training issues where the individuals who were doing the reviews were not doing them correctly, so there was a need to train staff; and then the last issue does have to do with transferring the applications and the application information between the exchanges and the Medicaid programs.

Mr. BILIRAKIS. And no corrective action has been taken. Is that correct?

Ms. YOCOM. At this point, CMS has taken some actions, but none that we consider sufficient to address the concerns.

Mr. BILIRAKIS. OK, thank you very much. I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman, and I now recognize the gentleman from Oregon, Dr. Schrader, for 5 minutes for questions.

Mr. SCHRADER. Thank you very much, Mr. Chairman. I appreciate you all being here. I want to get a little perspective, I guess, with the degree of fraud that we are worried about. Ms. Yocom, do you have any expertise, or any background, in what fraud has been historically in Medicaid or Medicare?

Ms. YOCOM. There really isn't a good estimate of fraud. There are estimates of improper payments in Medicaid——

Mr. SCHRADER. What would those be?

Ms. YOCOM. About 7 percent, if I remember correctly.

Mr. SCHRADER. OK. In both programs?

Ms. YOCOM. For Medicaid, yes, I do not know the number for Medicare.

Mr. SCHRADER. Medicare, it is somewhere about the same, between 5 and 10 percent in the literature. And in private insurance, which is what we are talking about with regard to the QHPs, at the marketplace; your own report refers to marketplaces. What is the fraud generally in those?

Ms. YOCOM. That is not known.

Mr. SCHRADER. Well, there is actually estimates that we have been able to get in the 1 to 1.5 percent range.

Ms. YOCOM. Would that be fraud or improper payments?

Mr. SCHRADER. Improper payments. So I am trying to get at whether or not—to keep this whole thing in perspective, would appear to me, based on the information that is out there, that improper payments and fraud is less in the marketplaces, where private and price has some incentive obviously to monitor what is going on. As has been alluded to here today with the advent of the Affordable Care Act, there has been an emphasis on access.

Mr. Bagdoyan, are you surprised at all that CMS would, perhaps, lean a little more towards access versus program integrity as they roll the program out?

Mr. BAGDOYAN. Well, obviously, Dr. Schrader, that is a policy call that CMS has made, and that is a defensible position from their perspective. The balance, as I said, clearly tilts toward providing access, but we also like to emphasize that program integrity, it is very important.

Mr. SCHRADER. Certainly that would be your job and I appreciate you doing your job. I don't think it is astonishing to any of us that access is extremely important to make sure these people who haven't had health care in the greatest country on Earth, and the most industrialized Nation, should at least be able to get a little bit of health care. And there is, obviously, personal responsibility because they do have programs.

Contrary to some of what we have heard today, there are ways and procedures by which Medicaid does check or recheck authentication. Isn't that correct, Ms. Yocom?

Ms. YOCOM. Yes, that is correct.

Mr. SCHRADER. Yes. That is quarterly or whatever, as I understand?

Ms. YOCOM. Yes, they are doing quarterly reviews right now.

Mr. SCHRADER. So there is a way, even though someone could, a determined criminal, as we have established, your shoppers are very determined, can defraud the system. I think that is commonplace in anything in America, unfortunately, but there is this way to catch them on the back end. And with the QHPs, there is the annual check with the IRS documents; is that correct, also, as a way to check on the eligibility?

Ms. YOCOM. That is generally correct.

Mr. SCHRADER. So we have got a system that is not perfect, but obviously there are some initial checks that the ranking member alluded to that, and Mr. Bagdoyan, you responded, so there are some initial checks. There is the review down the line. So it is not quite as profligate a system as some would paint it. Can it be better? I think the answer is absolutely yes.

I am trying to get at the nuts and bolts. The biggest issue I see coming forward is the nether land between Medicaid program and QHP program, as people move up or down the food chain with regard to their wages. Is there currently in place an opportunity for program integrity to check into that, besides just the year end checks?

Ms. YOCOM. There is. The conducting reviews of eligibility determinations that are made, not just in the states, but also in the Federal marketplaces, is a good place. The other really key issue is, at this point, CMS is doing eligibility reviews, but then they are also doing expenditure reviews and they need to connect those two together so that when they do identify errors, they can make sure that the matching rate is correct.

Mr. SCHRADER. If I were to interpret your comments and maybe Mr. Bagdoyan's too, it is the two programs talking to one another?

Ms. YOCOM. Correct.

Mr. SCHRADER. Medicaid and the QHP programs, for lack of better terminology, that we could work on.

The last comment I guess I would make is, as I understand, while the states have been responsive to some of the concerns that GAO has come up with. CMS, at least within this last year, did not find time or have the interest to perhaps do that. You will be monitoring this going into 2016 I assume, and we will get a report. From your understanding, CMS is more responsive now perhaps, than it was a year ago in terms of some of the concerns you have?

Ms. YOCOM. They have been with our recommendations, yes. And we have had good conversations with them about, specifically, ways they could adjust their processes.

Mr. SCHRADER. Well, I look forward to a healthier report next time, and appreciate all the access that has been—recognizes the gentleman from New Jersey, Mr. Lance, for 5 minutes for questioning.

Mr. LANCE. Thank you, Mr. Chairman, and good morning to the panel. As I understand it, CBO estimates that exchange subsidies and related spending this year is roughly \$77 billion, and next year the exchange in Medicaid-related spending may increase to \$116 billion. Given those very large amounts of money, even a small sample involves a significant amount of money. Would that be accurate, Ms. Yocom?

Ms. YOCOM. Yes.

Mr. LANCE. And so I think that it is relevant in our discussion here today that we are investigating, through your fine offices, significant amounts of taxpayer funds.

As you mentioned in your testimony, many low-income individuals are likely to switch between exchange coverage and Medicaid eligibility due to income volatility. Could you explain to us when and how is an enrollee notified that he or she is eligible for a different type of coverage? And can you walk the subcommittee through the process for an enrollee transitioning from one type of coverage to another?

Ms. YOCOM. Sure. At this point, the primary way that a change in coverage comes is the enrollee reporting a change in circumstance. So an individual who is on the exchange perhaps loses their job and no longer has coverage, and then goes to apply for Medicaid. We have three scenarios in our report that look at the potential for gaps and for duplication. The gaps have to do with the timing of the transition between moving from Medicaid to the exchange. The duplications have to do with the individuals failing to report a change in coverage, or their being enrolled in both places at once.

Mr. LANCE. Is this a complicated system for the person likely involved in these programs to navigate?

Ms. YOCOM. I would say there is a lot of complication, yes.

Mr. LANCE. Thank you. Mr. Chairman, I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentlelady from California, Ms. Matsui, for 5 minutes for questions.

Ms. MATSUI. Thank you, Mr. Chairman. I want to thank the witnesses for coming here today.

Mr. Bagdoyan, I would like to ask you a question regarding the use of self attestation, I think I am pronouncing it right, in the marketplace application process. When applying for coverage, a consumer may self attest, for example that their income is a certain amount under the penalty of perjury. In layman's terms, lying on your self attestation is against the law and subject to criminal penalties.

In your testimony, you describe in detail the processes that were used to maneuver vague identities through the marketplace system. In order to work through the system, the agency had to provide an attestation as to the accuracy and truthfulness of the application. Is that correct?

Mr. BAGDOYAN. Yes.

Ms. MATSUI. Now, last July, when you testified in front of the Senate Finance Committee on a similar secret shopper study, you had an interesting exchange with Senator Portman. In that exchange, you stated "We were able to get through via self attestation," and further went on to say, "We would view that as a control gap." For the record, would you acknowledge you made that statement?

Mr. BAGDOYAN. Sounds about right.

Ms. MATSUI. Just for the record, I would like to read the attestation that the secret shopper signed. "I am signing this application under penalty of perjury, which means I provided true answers to all the questions on this form to the best of my knowledge. I know

that I may be subject to penalties under Federal law if I intentionally provide false or untrue information.”

This is attestation that the GAO encountered. Is that correct?

Mr. BAGDOYAN. I believe so, yes.

Ms. MATSUI. Mr. Bagdoyan, I am sure you filed income taxes in the past. Do you recall signing your name after reading the following phrase: “Under penalties of perjury, I declare that I have examined this return and accompanying schedules and statements. And to the best of my knowledge and belief, they are true, correct and complete”?

While I understand limitations of a self attestation system, it has been proven over time that self attestation tied to audits and penalties is the best viable option. In fact, on its Web site, the IRS has the original 1040 form on display. Interestingly, it was introduced in 1913, and yet over an entire century later, the self attestations are essentially unchanged.

While the system isn’t perfect, no system ever is, it has been proven over time to be the best viable option, and I have yet to hear widespread news reports denouncing the use of self attestation in the tax system. While I welcome the GAO’s suggestion on this topic, I respectfully decline to ask any additional questions, since the GAO has not yet finished its review process, nor have they issued formal recommendations yet. And with that, I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentlelady. I now recognize the gentleman from Missouri, Mr. Long, for 5 minutes for questions.

Mr. LONG. Thank you, Mr. Chairman, and I will stick with my friend’s line of questioning on self attestation. I will start with you, Mr. Bagdoyan. Based on your written statement, it appears that in several instances, the exchanges accept applicants’ self attestation as sufficient evidence. Can you describe the instances where the only evidence provided was applicant self attestation?

Mr. BAGDOYAN. Well, I think all the information we provided on the applications, on the phone, for example, and then confirmed with submitting documents to that effect, to verify that the information we provided was, indeed, accurate, would be, in the broadest sense, a process of self attestation.

The marketplace reviews the documents, checks what we said on our application against what they have in hand in terms of a document. If they don’t see an alteration, they accept the self attestation as the truth.

Mr. LONG. OK. Do you think that relying on this self attestation is sufficient?

Mr. BAGDOYAN. It is probably not sufficient on its own. If the document is accepted at face value without any further check, that would be a material weakness.

Mr. LONG. And how often do you think that is done?

Mr. BAGDOYAN. I am sorry?

Mr. LONG. How often do you think that is done, where it is accepted without any further checking?

Mr. BAGDOYAN. Yes, sure, that is a fair question. In the two rounds of undercover that we performed, we are not aware of any kind of cross-check between any of the parties, either the exchanges or the state-level agencies.

Mr. LONG. OK, 100 percent comes to mind.

Ms. Yocom, let me ask you: In your report, you noted that in July, the CMS was to conduct a data match to identify consumers who may be dually enrolled in Medicaid and marketplace coverage. Do you know what the results of this data match were? And how frequently CMS plans to conduct such matching?

Ms. YOCOM. We do not know the results of that data match. My current understanding is that CMS is conducting reviews, but they are still in the process of determining how frequently they will do them.

Mr. LONG. Why do you not know the results?

Ms. YOCOM. They just have not been provided. At that point, we had a time period that was earlier than that.

Mr. LONG. What do you mean earlier than that? This is back in July.

Ms. YOCOM. Sorry, our coverage period that we were investigating did not include July. CMS offered that as additional information, but told us they were still analyzing the results.

Mr. LONG. OK.

Ms. YOCOM. I don't know if that is helping.

Mr. LONG. Given the financial implications of duplicate coverage for both the beneficiary and the American taxpayers, what is CMS doing to prevent such duplication from occurring?

Ms. YOCOM. We think there is more to be done, they are taking some actions, they are starting to do these reviews, but there needs to be more review of the determinations and more cross-checking across the exchanges and the Medicaid program.

Mr. LONG. OK. But apparently, it will take more than 90 days to get the results from what you said here today.

With that, Mr. Chairman, I yield back.

Mr. BAGDOYAN. If I may, Mr. Chairman, I would like to pick up on——

Mr. PITTS. You may respond.

Mr. BAGDOYAN [continuing]. What Mr. Long asked earlier. One instance of an agency actually checking with another entity as to the validity of some of the information that was provided, there was a State agency approach the Social Security Administration to double-check about the validity of a Social Security number. The SSA advised the State agency that that could not be a valid Social Security number, and the agency, nevertheless, proceeded to approve our application. So I just wanted to make sure that you had a full picture on that one.

Mr. PITTS. All right, the gentleman yields back. The chair now recognizes the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman. I thank the panel. It is pretty clear that the process of eligibility verification going between the various systems is probably one of the most complex that any agency or group of agencies would have to manage, so I am impressed that it can be done, for the most part, as effectively as it is being done. And I understand that CMS is taking steps to respond to some of the recommendations and findings of the GAO's report to refine the policies and procedures.

I wanted to ask you, Mr. Bagdoyan, you said that, I think there were 18 applications submitted as part of the secret shopper?

Mr. BAGDOYAN. Yes, we call them applications or scenarios, they are used interchangeably.

Mr. SARBANES. And initially, through the first submission process, which was largely online, I guess, you said there might have been a couple that were conducted by phone—

Mr. BAGDOYAN. That is correct.

Mr. SARBANES [continuing]. Initially. The online ones, the system of checks and balances did pick up some issues, and rejected them at that point, right?

Mr. BAGDOYAN. That is correct, yes. The online application process involves an identity proofing step, if you will. And we failed that initial step, we were directed to call the contractor, which is Experian, whose job it is to—

Mr. SARBANES. That is pretty good that you failed at the beginning.

Mr. BAGDOYAN. At the beginning, the story gets a little more complicated as you move through.

Mr. SARBANES. So we give a plus sign to the system for failing you at the front end.

Mr. BAGDOYAN. And we failed through the contractor, who then directed us—

Mr. SARBANES. So you failed twice. So the system called you out twice.

Mr. BAGDOYAN. Initially, yes.

Mr. SARBANES. Initially. So that is pretty good, because you then came back with, I guess, paper submissions.

Mr. BAGDOYAN. In one instance, yes, and then by phone on most of the other ones, and that is where the workaround and the control weakness occurs is that we used the system's own instructions to overcome its initial control.

Mr. SARBANES. Right. But you are getting in there pretty well versed in where to poke at the system to find these potential weaknesses, right? I mean, you have got more, I would presume, given your forensic experience, you are going to have more knowledge than even a fairly sophisticated person out there whose intent on committing fraud is to—where some of the weaknesses are, so you can poke at them. And I commend you for the heroic efforts which your people apparently undertook to explore all of those various weaknesses.

Mr. BAGDOYAN. If I may respond to that. When we started the work in 2014 for coverage year 2014, we had no idea what we would encounter. We were designed to act as typical consumers who got online; did whatever was instructed to do; went through the various steps, and when we reached the identity proofing step, we were caught, or flagged, if you will, referred to the contractor.

Mr. SARBANES. Let me interrupt. There is one way in which you can't actually behave like the typical consumer, unless you are going to tell me that your folks are subject to the perjury penalties that apply to somebody who checks that submission box after reading the fact—and I presume you have some kind of immunity?

Mr. BAGDOYAN. Yes, it is part of our investigative authority.

Mr. SARBANES. So they are just blowing right through that check in terms of the deterrent effect that it might have, right? Because they are reading this thing and saying, you are subject to penalty of perjury, and they are saying well, obviously, the investigator is doing the secret shopping, that is not going to affect us at all.

So actually, one of the most important things that operates on the typical applicant to give them pause, particularly if they are going through one, two, and three stages of submitting false documents is actually not operating in this instance. So to draw conclusions about the ability of this system of checks and balances actually deter that kind of fraud, I think, from this exercise, is a little bit questionable. And with that, I would yield back.

Mr. PITTS. The chair thanks the gentleman, and now recognizes the gentleman from Indiana, Dr. Bucshon, for 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Chairman. Thank you for being here, and I think, I just want to point out, it is unfortunate that some today in the hearing have gone after the messenger rather than listening to a message they may or may not want to hear, including occasionally discussing your own personal lives, which I find unfortunate; because, clearly, you are not here to keep people from getting benefits, but to make sure that people that are actually eligible for those, and I appreciate that work.

Mr. BAGDOYAN, according to CMS, when an applicant's information can not immediately be verified, the system is to notify the agency of inconsistency so they can be addressed later after eligibility is granted. Presumably, all of your fictitious applications should have resulted in generation of inconsistency notifications. Did the marketplaces follow up with your applicants to rectify these inconsistencies?

Mr. BAGDOYAN. We received extensive communication that our documents were submitted, and that they appeared to be correct, and that the inconsistency was resolved. There were some instances where the back and forth was more extensive than others. But in general, our coverage was sustained over time, yes.

Mr. BUCSHON. So also on your statement, you indicate, and some of this has been kind of answered, but four of eight applicants who applied for Medicaid coverage were not ruled in Medicaid, but were able to obtain subsidized exchange coverage. And while this can be seen as a positive sign that Medicaid eligibility determinations are working, it could mean that at least some of the applicants were unable to get Medicaid coverage, not because they were deemed ineligible, but because coordination problems between the Federal exchange and Medicaid. Is that correct?

Mr. BAGDOYAN. Yes, that would be the top line story there, the coordination involves exchange of information, exchange of data files, and that sort of thing that without knowing what was going on on the other side, we can only surmise that the failure to exchange information, at least at an adequate level, prevented us from getting a determination. And since we were pursuing the coverage, we decided to represent ourselves as having failed to obtain Medicaid and subsequently qualified for a QHP.

Mr. BUCSHON. Ms. Yocom, do you have anything to add to that that you haven't already talked about?

Ms. YOCOM. No.

Mr. BUCSHON. OK. I don't have any more questions, but I would just like to say that whatever the level of fraud is, the people that I represent want to make sure we are not wasting their hard-earned taxpayer dollars. So I think that some of the implication that this may be a minor problem that shouldn't be looked into because the dollar amounts or the level of fraud may be low, but when I talk to the people that I represent, I am sure they don't want their taxpayer dollars going for any fraud in the system, and I recognize there are challenges, and there are some things that you don't have the staff or the time to investigate. But I think your work is very important. I think any level of waste of the taxpayer dollars is important, and I appreciate your work. I yield back.

Mr. BAGDOYAN. Thank you.

Mr. PITTS. The chair thanks the gentleman. I now recognize Mr. Luján 5 minutes for questions.

Mr. LUJÁN. Thank you very much, Mr. Chairman. I want to pick up a little bit where my colleague from Maryland left off, just as I understand this. But before I do so, Mr. Bagdoyan, when were your findings presented to the committee?

Mr. BAGDOYAN. I am sorry?

Mr. LUJÁN. When did GAO send your findings to the committee, to the majority, to the minority?

Mr. BAGDOYAN. The statement was provided, I believe, mid-morning on Wednesday.

Mr. LUJÁN. Your testimony was provided?

Mr. BAGDOYAN. Testimony, yes. And we briefed staff the week before.

Mr. LUJÁN. You briefed staff the week before?

Mr. BAGDOYAN. That is correct, at their request.

Mr. LUJÁN. Were there any other documents before your testimony was submitted to the committee on Wednesday, were there any other documents submitted to the committee before you met a week ago?

Mr. BAGDOYAN. No. This was an extensive oral briefing, and I assume notes were taken.

Mr. LUJÁN. And so when you worked with your staff, Mr. Bagdoyan, to prepare for interviews with other individuals, would you say that more time or less time is better for you to be able to review documents before we get a chance to question?

Mr. BAGDOYAN. In general, I would say more time.

Mr. LUJÁN. Would it surprise you that the committee didn't receive information—the minority didn't receive information until 2 days prior to the hearing?

Mr. BAGDOYAN. That is a good question, Mr. Luján, but I followed the committee's rules as presented to me.

Mr. LUJÁN. I appreciate you doing that, but maybe we can all make sure we get the information to spread around so we can better prepare. I appreciate that, sir.

Mr. Bagdoyan, so the way that I understand it, GAO used the Federal Government—so you used your knowledge about documents with fraud prevention safeguards that were put in place, to be able to look into this process with Medicaid coverage and into the marketplace, correct?

Mr. BAGDOYAN. Yes, we had some knowledge, but again, we didn't know about the specific controls that were involved that we would likely encounter.

Mr. LUJÁN. And so through your investigation, GAO falsified identities to get coverage?

Mr. BAGDOYAN. That is correct.

Mr. LUJÁN. Did GAO, with each false identity, did you enroll into multiple marketplaces at once?

Mr. BAGDOYAN. There was one instance where we obtained coverage in additional—

Mr. LUJÁN. Not obtain, did you apply?

Mr. BAGDOYAN. Apply and obtained, yes.

Mr. LUJÁN. And did GAO pay multiple premiums for coverage as this was going through the process?

Mr. BAGDOYAN. Yes, that is part of the investigation.

Mr. LUJÁN. Do you think that an everyday person would pay multiple premiums to try to get coverage?

Mr. BAGDOYAN. I can't speculate on that, sorry.

Mr. LUJÁN. I think it would be challenging for an individual maybe to pay multiple premiums in multiple areas.

Mr. BAGDOYAN. That is an excellent question if I may clarify. That particular scenario was designed to see whether the issue of identity theft would come in. So that is a specific scenario.

Mr. LUJÁN. Let's talk about identity theft. So under penalty of perjury, these documents were submitted?

Mr. BAGDOYAN. That is the up-front penalty, yes.

Mr. LUJÁN. But GAO is exempted from that, as we found out from—

Mr. BAGDOYAN. Investigative authority, that is correct.

Mr. LUJÁN. So an everyday person, in this case, would, I guess assumption would be made, that if they paid multiple premiums for coverage, that they would still waive the penalty of perjury, and be subject to between \$25- and \$250,000 in fines. Is that correct?

Mr. BAGDOYAN. That is the case, yes.

Mr. LUJÁN. Does GAO assist in any investigations to go after perpetrators of fraud with any of our agencies?

Mr. BAGDOYAN. Yes, it is an excellent question. We do, as a matter of course, whether it is an investigation or an audit. We do make referrals to the appropriate Office of Inspector General, or as appropriate to the Department of Justice, or both.

Mr. LUJÁN. During this investigation, did you identify any fraud?

Mr. BAGDOYAN. Not on real individuals, no.

Mr. LUJÁN. Not on real individuals?

Mr. BAGDOYAN. That was not designed as such in the beginning.

Mr. LUJÁN. I appreciate that answer.

Mr. BAGDOYAN. Sure.

Mr. LUJÁN. It was, in fact—the 14 secret shoppers that went through the online parameters were stopped, it worked.

Mr. BAGDOYAN. The initial ID proofing, as I told Mr. Sarbanes, yes. But eventually we found a workaround without having foreknowledge.

Mr. LUJÁN. And did the workaround include ignoring the filing under penalty of perjury?

Mr. BAGDOYAN. Yes.

Mr. LUJÁN. No one that submitted these false documents will go to jail?

Mr. BAGDOYAN. Right.

Mr. LUJÁN. Because there is an exemption?

Mr. BAGDOYAN. That is right.

Mr. LUJÁN. If a normal person, outside of being exempted under GAO, would submit these documents and they got caught, what would happen to them?

Mr. BAGDOYAN. They would probably be subject to the terms of whatever—whether it is the fine or—

Mr. LUJÁN. Twenty-five to \$250,000 in fines and jail time, potentially. Mr. Chairman, I appreciate this hearing, but I hope that we get all of the facts put on the table. But that we also get the recommendations that GAO has made to CMS, and to others presented to us, that way we can work on those together. And I am hopeful, Mr. Chairman, that as we do this, there is agreement with all of our colleagues to make sure we improve this process, as opposed to trying to find a way to try to kick everyone off the rolls, including the 423,000 individuals who were caught, whether it was for mistakes or whatever may be done through this process, that were removed from getting coverage in the marketplace.

I thank you very much, Mr. Chairman. I yield back my time.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Virginia, Mr. Griffith, for 5 minutes of questions.

Mr. GRIFFITH. Thank you very much. I find this discussion interesting. I would say, Mr. Bagdoyan—I hope I said that correctly.

Mr. BAGDOYAN. Yes.

Mr. GRIFFITH. I would say I kind of wish you had brought up earlier, I do appreciate Mr. Sarbanes and others for bringing up that you all have immunity, but the first couple of times it came up, was this done knowing there that was penalty of perjury? It sounded like you all were engaged in criminal conduct, so I am glad that we got that clarified, and obviously, in order to do an investigation, you would need such immunity from prosecution for doing that.

Now my background, which you probably don't know, is that for 28 years, I practiced small town law, the great predominance of that over the years was in the criminal defense field. Having represented a number of criminal defendants, I can assure you, and you are probably aware as well, that there are numerous people who ignore the perjury clause on all kinds of Federal documents, including IRS documents. Wouldn't you agree that those people who are larcenous in nature are likely not to pay much attention to the perspective penalties?

Mr. BAGDOYAN. Yes, I would say if they have intent, they would probably just ignore that.

Mr. GRIFFITH. They would probably disregard that. So when folks say, yes, but they had to sign off on the statement that you didn't have to worry about, or your secret shopper, so to speak, didn't have to worry about, that does not, in my experience, bode as a great impediment to going forward if you have a larcenous intent.

Likewise, they have not previously been involved in the criminal justice system while the maximum penalty is jail time and up to, I think, \$250,000 fine, it may sound fairly stiff, a first-time offender is not likely to get anywhere near the maximum, and is un-

likely, in a crime of this nature, to receive jail time. Would you not agree?

Mr. BAGDOYAN. I don't really have an opinion on whether that would happen or not.

Mr. GRIFFITH. I did find it interesting that they wanted to point out that there were places that there was a stop, but it was a temporary stop, and you were very good to point out that, yes, but on other tries, or workarounds, there were ways to do it. I noted with some interest in the document, which, by the way, does not appear to be all that long. I have heard folks complaining about how they didn't get it in time. I have read it while I have been sitting here this morning. But I noted that in one spot, in particular interest, that you all gave Social Security numbers that were impossible Social Security numbers.

Mr. BAGDOYAN. That is correct.

Mr. GRIFFITH. They didn't match up with anything that would possibly be used.

Mr. BAGDOYAN. They had not been issued ever by the Social Security Administration.

Mr. GRIFFITH. And for the 10 undercover applications that used these numbers that would not possibly have been involved, only one picked up as a trigger and, that was in the State of Kentucky. And yet, even though—I went through the material—even though Kentucky picked it up, they did give them coverage anyway.

Mr. BAGDOYAN. That is correct.

Mr. GRIFFITH. And so help us figure out this impossible Social Security number, but we will give you coverage in the meantime. Is that accurate?

Mr. BAGDOYAN. That is correct. And they did contact SSA, and SSA said that is not a good number and whoever the representative or the specialist was overrode that advisory and provided coverage.

Mr. GRIFFITH. And provided coverage anyway. And also, when the fictitious applicants, I think there were four of those who said that their employer did not provide the minimum essential coverage, there was no check back to see with their employer if they, in fact, did qualify for an employer who did not provide the minimal essential coverage. Is that also accurate?

Mr. BAGDOYAN. That is correct. We set up a fictitious company for that purpose with contact information and we got no hits.

Mr. GRIFFITH. That is the kind of thing that this hearing is about and is troubling to a lot of us. Whether you like the program or don't like the program is not the issue. The issue is, if we are going to go have a program at the Federal Government level, let's at least have some tests out there and some checks back over time to make sure that people are still eligible.

I appreciate the work that you all do. I appreciate you being here this morning. And with that, Mr. Chairman, I yield back.

Mr. BAGDOYAN. Thank you.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Massachusetts, Mr. Kennedy, for 5 minutes of questions.

Mr. KENNEDY. Thank you, Mr. Chairman. I want to thank the witness for their work and the work they do. I think I can say, I

echo the comments of all my colleagues when I say that program integrity is absolutely critically important. We want to make sure that in a program such as this, that beneficiaries that are in need of these benefits and services are getting the services that they need, particularly when it comes to something like access to health care.

I want to build off an exchange of a couple of my colleagues, but first, Mr. Bagdoyan, I just want to make sure that I have your testimony clear in my head. We have talked through a number of front-end procedures, identity proofing and document requests already to reiterate online applications for the secret shoppers were caught and flagged. But let's not go out the back-end side, if you can.

So for the fake applications that were created and received initial QHP coverage, a tax return was not filed, right?

Mr. BAGDOYAN. That is correct.

Mr. KENNEDY. So there is an additional check about making sure that those who do get coverage end up getting those records squared with tax attorneys, and that last check not done, right?

Mr. BAGDOYAN. That is correct.

Mr. KENNEDY. So did you know that any discrepancy will have to be repaid in full if there is a discrepancy paid by the beneficiary back to the Federal Government?

Mr. BAGDOYAN. Yes, we had that awareness.

Mr. KENNEDY. And were you aware that state Medicaid programs are required to also go through extensive eligibility redetermination process annually as well?

Mr. BAGDOYAN. In general terms, yes.

Mr. KENNEDY. So the process actually works sometimes too well, and we unintentionally disenroll eligible beneficiaries. I can also tell you that from my own State of Massachusetts, that it definitely works to check as an additional protocol, an additional control.

I want to touch base a little bit on the documents that you talked about earlier with response to some of the questions my colleagues asked. You said that your team was able to produce those documents with supplies and equipment that is readily dealt with. Is that right?

Mr. BAGDOYAN. That is correct.

Mr. KENNEDY. And you mentioned that you had a team of folks that were able to, with no prior knowledge, to somehow find their workaround through the system, right?

Mr. BAGDOYAN. That is correct.

Mr. KENNEDY. How many folks are on your team, sir?

Mr. BAGDOYAN. My mission team has about 55 staff.

Mr. KENNEDY. And how—average education level?

Mr. BAGDOYAN. Most would have masters or above.

Mr. KENNEDY. How much time did you spend working on that workaround?

Mr. BAGDOYAN. On the workaround itself? That occurred in real time, so we just followed the instructions of the system in real time.

Mr. KENNEDY. But you have a team of 55 people, the majority of whom with master's degrees, with the resources of a fully—at least, I should say, somewhat partially resourced Federal office to

actually achieve this workaround, which is not necessarily the, one would say, potentially reflection of the average resources education level, or teammates of your average U.S. constituent.

Mr. BAGDOYAN. Not all 55 worked on it at the same time, I wish they had.

Mr. KENNEDY. Me, too.

Mr. BAGDOYAN. But it was a much, much, much smaller team of less than half a dozen basically.

Mr. KENNEDY. Still a half dozen folks with master's degrees and those resources, fair?

Mr. BAGDOYAN. Fair.

Mr. KENNEDY. OK. So now, and most of them have a background as being professional investigators as well, yes?

Mr. BAGDOYAN. The people who actually do the work, they are—yes, they are investigators.

Mr. KENNEDY. So we are talking about a half dozen folks that are professional investigators with the resources of the Federal Government trying to do this?

Mr. BAGDOYAN. That is the representation.

Mr. KENNEDY. OK. Now, we talked about it a little bit before with my colleague, the fact all of this is done underneath the penalties of perjury, and you went through the fact that those include potential civil fines and potential criminal liability as well, correct?

Mr. BAGDOYAN. That is correct.

Mr. KENNEDY. So what, I guess, I am trying to understand, sir, is we are talking about the fact that there are—and you conceded in the first page of the summary sheet the fact that this was done for a number of individuals cannot actually be accurately generalized, the result of the findings cannot be actually generalized to a larger population.

Mr. BAGDOYAN. That is correct.

Mr. KENNEDY. But the concern would be, obviously, that there are a large number of individuals that can be using false documentation in order to get coverage?

Mr. BAGDOYAN. That is the control we missed, yes.

Mr. KENNEDY. Just so I am able to understand, the concern is that there would be tens of thousands, or hundreds of thousands of individuals in this country that are willing to risk the penalties of perjury, \$25,000 to \$250,000 fine, plus potential criminal liability in order to get access to affordable health care coverage?

Mr. BAGDOYAN. That is the risk.

Mr. KENNEDY. That is the risk.

Mr. BAGDOYAN. That is correct.

Mr. KENNEDY. And are you aware, that in about another half hour, this body is going to vote to repeal the Affordable Care Act for the 61st time.

Mr. BAGDOYAN. I didn't know that.

Mr. KENNEDY. So we are having a hearing which is critically important to examining program integrity, and we are trying to focus on the program integrity while we recognize the fact that there are tens of thousands, potentially hundreds of thousands of folks, which is the concern of this report, that are willing to risk these liabilities in order to get access to affordable health care, the very

program the majority is trying to repeal for the 61st time in an hour.

I yield back.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman. And I am sitting in this last chair means I am one of the newest members of the committee. And I have to admit, when I came here, I always asked my staff, tell me the tone of the hearing and generally a hearing like this they would say, this is an informational hearing, meaning bipartisan. So I have to tell you, I have sat here and listened to the comments and questions, and I am somewhat befuddled that here we are having a hearing on what I think of as being waste, fraud, and abuse. I always thought those kinds of hearings and trying to identify problems didn't have a partisan take to it.

So, I just would start by saying I am extraordinarily disappointed in the other side of the aisle here in trying to take away from your hard work, just identifying potential problems to save the taxpayers money in what we call waste, fraud, and abuse. So personally, I thank you for what you have done, and certainly know you are doing your best every day to then take these recommendations back to CMS to save taxpayers money, or as you said, Mr. Bagdoyan, identify weaknesses. That is really what this was about what you called your control vulnerabilities, the controls didn't work.

Just a couple of commonsense interesting questions here. Since these were fictitious—Social Security numbers ultimately got through, did these individuals ultimately sign up with these totally bogus Social Security numbers, and effectively obtain coverage? Is that the primary identifier of a policy, the Social Security number?

Mr. BAGDOYAN. It is not a condition of eligibility but it is identity proofing, yes.

Mr. COLLINS. So I will say, as a Member of Congress, and as an American, I am befuddled that in the era of big data, that ultimately somebody gets a policy with an identifier that couldn't exist and that there is no cross-checking again. The big data world that we live in, I am somewhat astounded that that vulnerability exists. That should be an immediate disqualifier.

So I am very not happy to hear you tell us that, but I would think that should be something that could be easily on the recommendations side of cross-check into the Social Security data files would eliminate that piece of it.

Now the other thing, if someone is on Medicaid, they don't pay anything, correct? And if this was an expansion, the States don't pay anything, so this is 100 percent on the Federal Government's back.

If the individual ends up on Medicaid under, certainly, the expansion portion, and so I am worried about the individual who works for a small business, who provides coverage, that individual, under, certainly, the expansion of the poverty level, would qualify under Medicaid, legitimately qualify. They have their own Social Security number, they are who they are, they live where they live. Income records indicate they meet all the criteria. But if they sign up on their employer plan, they have to pay some percentage of

that coverage, whether it is individual or family coverage, but if they can come in under Medicaid, then they don't pay anything.

So my worry would be back to somebody saying that they work at XYZ company, but XYZ doesn't provide healthcare coverage. So they are not being honest in that regard. And therefore, I am concerned what you are telling us, I think there was no cross-checking back on that piece. So somebody who, low-income, wants coverage but has an employer providing it, is cheating or being deceptive in saying, no, my employer doesn't offer it, therefore they get it. Is that some of the scenario?

Mr. BAGDOYAN. Yes, the scenario, itself, was the applicant claiming that whatever the employer did provide did not meet the minimum standard, so they were seeking better coverage. And as I mentioned to another member earlier, we did set up a fictitious company for that very purpose with contact information. And as I mentioned, we did not get a single hit for verification purposes.

Mr. COLLINS. So, just getting back and me initially thinking this was going to be a bipartisan informational hearing, I think a couple of things is, the Social Security check should be a no-brainer, but secondarily, a very big issue of potential—and we use the word “fraud,” but this is a low-income individual trying to get coverage at no cost, but happens to work for a company that does provide a policy that meets the standards, but that person has to pay something into that; that that is very much a real-life scenario that could have happened that should be addressed in some way through that verification of somebody suggest that their company doesn't meet the minimum standard. Somebody should check on that. That is, I am assuming, what a recommendation might be.

Mr. BAGDOYAN. That is the intent of the check, yes.

Mr. COLLINS. Yes. Well, thank you all for the work that you do on behalf of the taxpayers.

Mr. BAGDOYAN. Thank you.

Mr. COLLINS. With that, Mr. Chairman, I yield back.

Mr. PITTS. The chair thanks the gentleman, now recognize the gentleman, Mr. CA AE1Rdenas, 5 minutes for questions.

Mr. CA AE1RDENAS. Thank you very much, Mr. Chairman. The question to Mr. Bagdoyan. Are you familiar with the term “presumptive eligibility”?

Mr. BAGDOYAN. In general, yes.

Mr. CA AE1RDENAS. What we are talking about today, is this a program that has presumptive eligibility, or is it something that people have to properly and appropriately identify that they can or should be eligible before they actually receive their benefits?

Mr. BAGDOYAN. Yes, it has to be confirmed that they have eligibility that met all the requirements of the application process, they have submitted documents to clear any inconsistencies that were created as part of that.

Mr. CA AE1RDENAS. So it appears that what we are discussing today isn't so much whether or not the Affordable Care Act law, in and of itself, encourages individuals who are not eligible to apply, receive services, and then after the fact, perhaps, be found out that they were not qualified.

Mr. BAGDOYAN. I presume the law would not encourage that to happen.

Mr. CA AE1RDENAS. Correct. Because it is not a presumptive eligibility. Presumptive eligibility is not part of this law, correct?

Mr. BAGDOYAN. That is my understanding. And as I mentioned earlier, CMS told us that the agency had to balance access with program integrity. We see, based on our work, that access has a tilt in its favor at this time.

Mr. CA AE1RDENAS. OK. So would you say that it is being utilized as a presumptive eligibility program or not?

Mr. BAGDOYAN. That type of analysis was not within the scope of our work. Our scope included testing controls—

Mr. CA AE1RDENAS. Sure.

So let me ask this question: So are there some effective controls in the process that—due to your research and your analysis and your efforts?

Mr. BAGDOYAN. Right. As I responded to questions from members and as some members pointed out, the first step of the application process involved something called identity proofing.

Mr. CA AE1RDENAS. Correct.

Mr. BAGDOYAN. And that flag, we failed to clear online, and then we failed to clear it with the contractor as the next step. But again, following the system's own instructions, we were able to work around that control by engaging in a phone application.

Mr. CA AE1RDENAS. OK. So, by and large, based on what you have been able to uncover, is it a failed system or a flawed system of identifying who is or is not eligible?

Mr. BAGDOYAN. In terms of failed and flawed, there are weaknesses is the best way to describe it.

Mr. CA AE1RDENAS. OK. So that is more in the genre of flawed rather than failed, wouldn't you say, based on what you have been able to glean—

Mr. BAGDOYAN. Based on what we have done so far, right. And the forensic aspect of our work would give us a better idea of whether it is a failed or flawed or perfectly working system.

Mr. CA AE1RDENAS. And who is in charge of doing that forensic analysis of your work?

Mr. BAGDOYAN. That is done under my direction as well.

Mr. CA AE1RDENAS. OK. And when will you have that done?

Mr. BAGDOYAN. We are working on it. We received the data set from CMS for coverage year 2014. We are in the process of assessing whether the data are even reliable for us to make our analyses. If they are not, we won't be able to proceed. If they are, we will go ahead and do that, and we expect results, assuming we can proceed some time next year.

Mr. CA AE1RDENAS. Do you feel comfortable that the amount of resources that were made available to you and the budgetary decisions, et cetera, on this effort that you embarked on, was it robust enough for you to feel confident that you could go out there and do enough work so that you could eventually get to the forensic analysis and have a strong conclusion as to how good or bad this process is?

Mr. BAGDOYAN. Yes. I think we have a solid plan in place. It is well-staffed, and the resources are adequate for that purpose.

Mr. CA AE1RDENAS. OK. So you felt comfortable that the amount of resources that were made available to your department, you

were able to bifurcate those resources into the effort that you put together was good enough, big enough, funded well enough?

Mr. BAGDOYAN. Yes, I would say on balance, that is correct.

Mr. CA AE1RDENAS. OK. Well, I hope that it bears out that it was good enough for you to come to a comfortable conclusion, because just by my thinking, 50 states, some participating, some not, the number of fake applicants, et cetera, by my view, is a bit small, but hopefully, like you said, there was big enough effort for you to come to some strong conclusions.

I have one last question. Of the fake names, how many of them were more Russian in nature or German in nature, or Spanish in nature, what have you, the fake names that you put together to try to get through this process?

Mr. BAGDOYAN. It is a mix of names. We didn't pick any particular ethnic or other group to create the identities.

Mr. CA AE1RDENAS. So no ethnic group, name-wise, was over—

Mr. BAGDOYAN. I don't recall.

Mr. CA AE1RDENAS [continuing]. Sampled in this? OK.

Well, I would love to see those names eventually. Thank you very much.

Mr. BAGDOYAN. Thank you.

Mr. CA AE1RDENAS. I yield back.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you. And thank you for what you have done here.

First, let me ask this: Mr. Bagdoyan, when someone is testing out how a system works, do the companies, in general, run potential names through and see what works? Whatever the company is, whether it is Amazon, seeing if one can order a book, or it is Walmart, isn't that how generally people do that? They will put some name in and test it out?

Mr. BAGDOYAN. In the private sector, from my personal experience, that is an extensive part of what a company does, yes.

Mr. MURPHY. And we know that the initial rollout to the Affordable Care Act, as well as state exchanges, were filled with serious problems. And we had heard previously, through many people in our committees who were involved with the state and the Federal rollout, that they had even consulted with advisers, who said that there was going to be serious problems with security systems, and I assume that under those circumstances, they ran names through and see if the information was secured. So I am assuming this is standard practice. So let me ask a couple of questions here.

Ms. Yocom, in your report, you had talked about people with coverage gaps or they had also some duplication. Do we have any idea what the average or the number is in terms of number of people who have a coverage gap? Do we have any idea what the number is?

Ms. YOCOM. We do not, no.

Mr. MURPHY. OK. So out of the millions of people enrolled, we just simply don't know. How many may have a plan, they lose it, and they go on to Medicaid, or they are on Medicaid, so we don't know—

Ms. YOCOM. No.

Mr. MURPHY. But there are also people who may have duplication, overlap, which cost the taxpayer, cost the government. Do you have a number, idea of how many that is?

Ms. YOCOM. We do not have a national number. We did talk with issuers and also with states who had done some analyses, and right now, those numbers don't appear to be large, but—

Mr. MURPHY. When you say "don't appear to be large," are we talking thousands, hundreds of thousands, millions?

Ms. YOCOM. Like, one insurer identified about 18 individuals who were covered in both.

Mr. MURPHY. OK. Fair enough.

Ms. YOCOM. And that is a single issuer in a single state.

Mr. MURPHY. I am concerned about those from the standpoint of the taxpayers, and further, most concerned about those who lose coverage and don't have health care. But we don't know what that number is, though?

Ms. YOCOM. Right. We don't have a good number of that, no.

Mr. MURPHY. All right. But if someone has duplicate coverage, are they counted twice when we are counting how many Americans now have coverage under the Affordable Care Act?

Ms. YOCOM. Conceivably, they could be counted twice. So they could be counted under the exchange, and then also as a Medicaid enrollee, so I would say yes, that is possible.

Mr. MURPHY. So as we are looking at this and we are looking at huge cost overruns, do you have any idea how many people are fraudulently signing up for?

Ms. YOCOM. No, we do not.

Mr. MURPHY. Mr. Bagdoyan, can you extrapolate from your data how many people are gaming—

Mr. BAGDOYAN. Absolutely not. As I mentioned earlier, this is not generalizable. It is not designed to extrapolate any rate of fraud.

Mr. MURPHY. It was just a preliminary study?

Mr. BAGDOYAN. And it is preliminary. As I said, we are looking at the entire enrollee database of 2014. If that database proves to be reliable enough for us to conduct analyses, we might have a better idea later on.

Mr. MURPHY. So related to some questions you were answering before, I just want to be sure of this: Is this common practice among other areas of the government to test the system to see if it is vulnerable to fraud?

Mr. BAGDOYAN. Well, GAO does that as a matter of course, and as part of its broader charge to—

Mr. MURPHY. So is it generally-accepted valuable practice to—

Mr. BAGDOYAN. It is, yes.

Mr. MURPHY [continuing]. To test to see if fraud—

Mr. BAGDOYAN. Control environments, you may be familiar with the green book; it is a thick document that lays out the internal controls for the Federal Government agencies. They are required to follow those, and part of GAO's work either through audit and/or investigation—

Mr. MURPHY. But if you don't do this, how do you figure out if there is fraud in the system? Do you simply ask people if they have defrauded the system? So they ask a show of hands how many peo-

ple are gaming the system, and which is, obviously, not going to do anything?

Mr. BAGDOYAN. Yes, you would have to do the work. Asking questions is not sufficient.

Mr. MURPHY. So this is just the way to do it. And as a taxpayer, and as a Member of Congress protecting the taxpayers, that seems to make sense to me, you have to test the system and find it out.

I go back here, and we have had, for example, Secretary Sebelius before us a couple of years ago. When the Affordable Care Act first came out, we talked about 35 or 45 million Americans without any health insurance coverage. And now what we are talking about, I hear different estimates, 9, 10, 11 million, whatever it is, of people who now have coverage. And so we had asked her, of that, how many were Medicaid-eligible for, but didn't apply but now have it? How many were not Medicaid-eligible for but now have it because the number went up? How many were eligible for private insurance but chose not to take it? How many did have insurance but their coverage got the pink slip because of the new standards for health care, so now they have to sign up for something new? And how many of these groups were generally folks that did not have insurance before and now could have it? And she said, there is no way of telling. We just wouldn't have those numbers.

So I am puzzled by it, because out of this number of 9, 10, 11 million, I still don't know how many people the Affordable Care Act is helping. It truly wanted to help people who didn't have coverage and now have coverage. But of that, too, what you are telling me is, and of that, we don't know how many people may be gaming the system, and, in some cases, some people could even potentially say, an employer could even say, we don't have coverage here, but here is how to get coverage but nobody has to pay, or here is how you can qualify for Medicaid, when you don't really have it. Am I correct that people could potentially do that?

Mr. BAGDOYAN. I assume so, if there was intent, they could attempt it.

Mr. MURPHY. OK. And we won't judge their intent. But it seems to me, and I know that there is an old psychological principle that people tend to ascribe motives in others that they live in their own heart. I would hope that both sides of the aisle here would try to say, how do we fix this system, how do we deal with the defrauding the system so we don't have that? I hope that is a result of this hearing. I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from New York, Mr. Engle, 5 minutes of questions.

Mr. ENGEL. Thank you very much, Mr. Chairman. Obviously, nobody wants fraud. We need to root it out. But we don't want to use it as a reason to kill the program. I think the program is very important and is working well for the American people.

So, Ms. Yocom, I would like to ask you a bunch of questions, so I would like to request you keep your answers short, because I have a whole bunch of questions for you.

Ms. YOCOM. I will do my best.

Mr. ENGEL. I want to talk to you about the issues of coverage gaps and duplicate coverage. Can you walk through the reasons

why coverage gaps might occur for individuals transitioning between Medicaid and marketplace coverage?

Ms. YOCOM. Yes. It is basically a difference of timing and the dates, and when the coverage becomes effective.

Mr. ENGEL. Thank you. The Affordable Care Act made a number of changes to streamline eligibility requirements and enrollment processes between Medicaid and marketplace coverage, but still, there is some inherent difficulty in coordinating coverage across multiple programs. So can you walk us through—again, please keep it as brief as you can—your recommendations to CMS to reduce the likelihood of coverage gaps and the impact of such gaps on beneficiaries?

Ms. YOCOM. Yes. Our recommendations are really around testing, testing the eligibility processes and identifying if there are common mistakes that keep happening, and then providing fixes to those.

Mr. ENGEL. And is it the case that CMS has agreed with your recommendations?

Ms. YOCOM. They have.

Mr. ENGEL. Thank you. I would like to ask you about the possibility of duplicate coverage through Medicaid and the marketplaces. Why might this occur?

Ms. YOCOM. It could occur for a couple of reasons. The most basic is that an individual may fail to resign their coverage; they have a change in circumstance, and they forget to notify the marketplace.

Mr. ENGEL. While I understand that there is always room for improvement, CMS has significant safeguards to minimize the impact of duplicate coverage; is that not correct?

Ms. YOCOM. There are safeguards in place. We would suggest that more are needed.

Mr. ENGEL. For instance, APTC that is paid out for enrollees who are terminated for nonpayment of premiums are recouped from insurers. Am right about that?

Ms. YOCOM. Yes.

Mr. ENGEL. And CMS requires insurers to update their prior month enrollment each month, and recoups APTC provided for issuers for terminating individuals; is that not correct?

Ms. YOCOM. That is correct.

Mr. ENGEL. Additionally, can you talk about the periodic data matching that CMS has announced to help ensure that consumers enrolled in Medicaid are not also enrolled in the marketplace plan?

Ms. YOCOM. Right. They are just beginning to conduct these, and, once again, are sharing if there are consistent patterns, sharing what needs to be done to fix it.

Mr. ENGEL. So CMS conducts periodic and regularly scheduled data matches to identify duplicate coverage and will send notices to individuals with duplicate coverage to immediately end their marketplace coverage, if they are enrolled in Medicaid. Future schedule for PDM will be determined based on a number of factors, including the level of effort required by state and Medicaid agencies; is that correct?

Ms. YOCOM. Yes. Our concern is that they haven't yet settled on how periodic to be, and they haven't settled on how extensive those

requests are. And we think that is going to be important for them to figure out and apply.

Mr. ENGEL. So what I have just said, is that a reasonable approach by the agency?

Ms. YOCOM. It is. I think more surety on the periodicity of the reviews would be important.

Mr. ENGEL. OK. It is also the case that some duplicate coverage is allowable. Is that not right?

Ms. YOCOM. That is correct. There are scenarios where it is allowed under the statute.

Mr. ENGEL. For instance, when a case is transferred to the Medicaid agency for a decision on eligibility, the individual doesn't have to end his or her subsidized coverage in a QHP until the month after he or she is determined eligible; is that correct?

Ms. YOCOM. Right. And that is where these checks come in. That is why those checks are important, because it can be cut off earlier and not extend, the duplicate coverage.

Mr. ENGEL. Thank you. Would you agree that the best practice at that point is for the marketplace to end eligibility for APTC once an individual has been determined eligible for Medicaid as some States do?

Ms. YOCOM. Yes, in general. And CMS has said that they are working on a way to make that happen more automatically. Right now it is not automatic.

Mr. ENGEL. So CMS is definitely considering that; am I right?

Ms. YOCOM. They are considering that.

Mr. ENGEL. Right. Right. Well, thank you very much.

Mr. Chairman, I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman.

That concludes the questions of the members present. As usual, we may have follow-up questions. Members who were unable to attend may provide us with questions in writing. We will submit those to you. We ask that you please respond promptly if we do.

And I remind the members that they have 10 business days to submit questions for the record. They should submit their questions by the close of business on Friday, November 12th.

Thank you for your testimony. Thank you for your work on behalf of the taxpayers. Thank you for your efforts to provide integrity to our programs to make sure that those who are eligible to receive assistance receive that assistance. And a very good hearing, very important hearing. And without objection, the subcommittee is adjourned.

[Whereupon, at 11:16 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
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November 19, 2015

Ms. Carolyn Yocom
Director
Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

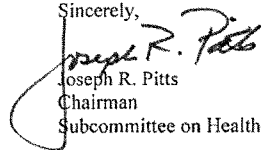
Dear Ms. Yocom:

Thank you for appearing before the Subcommittee on Health on October 23, 2015, to testify at the hearing entitled "Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on December 3, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment



U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

December 3, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This letter responds to your request that we address questions submitted for the record related to the October 23, 2015, hearing entitled *Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations*. GAO's responses to these questions are enclosed and are based on previous work related to the areas addressed.

If you have any questions about these responses or need additional information, please contact Carolyn L. Yocom at yocomc@gao.gov or call (202) 512-7114.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Carolyn L. Yocom".

Carolyn L. Yocom
Director, Health Care

Enclosure

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Post-Hearing Questions for the Record
Submitted to Carolyn Yocom, Director, Health Care
U.S. Government Accountability Office,
From the Honorable Joseph R. Pitts

“Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations”

October 23, 2015

The Honorable Representative Joseph R. Pitts

1. **Given the 100 percent federal funding for the newly eligible Medicaid beneficiaries, states obviously have a financial incentive to increase the proportion of applicants and expenditures for that population. Your report indicates that CMS officials said that their expenditure reviews are primarily intended to ensure that states are correctly grouping expenditures for the different eligibility groups as initially determined, not whether the determination is correct.**
 - a. **What exactly does that mean and what is CMS checking versus not checking as part of these reviews?**

What this means is that there is a disconnect between the determination of eligibility and the determination as to whether the appropriate matching rate has been used in reimbursing states for Medicaid claims. As part of its oversight responsibilities, CMS reviews state-reported expenditures on a quarterly basis. CMS has modified this review process to include an examination of expenditures for different groups of enrollees, since the federal share varies by eligibility group. Specifically, CMS staff must select a sample of different types of enrollees—including at least 25 PPACA-expansion eligible enrollees, 10 state-expansion eligible enrollees (where applicable), and 5 traditionally eligible enrollees—and examine their expenditures to ensure that they were categorized as expenditures for the correct eligibility type. CMS accepts the initial eligibility determination as correct for the purposes of the expenditure review, and checks to ensure that states are correctly grouping expenditures for the different eligibility groups. However, there is a disconnect because CMS does not use this review to assess the accuracy of the initial eligibility determination. Instead, the agency relies on pilot eligibility reviews, conducted by the states and CMS contractors, to assess initial eligibility determinations. Although the purposes of the CMS-64 expenditure review are distinct from the eligibility review, the information gained from the pilot eligibility reviews on state eligibility determination errors could be useful in identifying potentially erroneous expenditures that require further review by CMS. Consequently, we recommended that CMS use the information obtained from eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately.

- b. **What, if any, safeguards has CMS instituted to ensure that federal taxpayers are not paying more than their share of states' Medicaid programs?**

CMS has implemented interim efforts—pilot eligibility reviews and the eligibility support contractor program—to assess the accuracy of state Medicaid eligibility determinations; however, as we reported, these efforts generally do not assess the accuracy of federal Medicaid eligibility determinations. As we reported in October 2015, for the states in which

the federal government performs eligibility determinations, there is a gap in assuring that the determinations are accurate. We recommended that CMS take action to improve the effectiveness of its oversight of eligibility determinations and increase assurances that states' expenditures are appropriately matched.

2. Your reports contain several recommendations for CMS. What actions has CMS indicated that it would take in response to GAO's recommendations? Do you think these actions are sufficient to address the concerns raised?

Across these two reports, we made five recommendations. While CMS generally concurred with our recommendations, it is too soon to determine whether the actions it has taken or plans to take will be sufficient to address the concerns raised. We will monitor CMS's efforts to address these recommendations.

We made two recommendations to improve the effectiveness of CMS' oversight of eligibility determinations and increase assurances that states receive an appropriate amount of federal matching funds.

- In written comments to our October 2015 report, HHS concurred with our first recommendation that CMS conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary. HHS noted that federal eligibility determinations in two states were being reviewed by the eligibility support contractor, and stated that federal determinations would be examined under the Payment Error Rate Measurement (PERM) program, used to measure improper payments in Medicaid. However, the eligibility component of the PERM will not resume until 2018, and in the interim, without a systematic assessment of federal eligibility determinations we remain concerned that CMS lacks a mechanism to identify and correct federal eligibility determination errors and associated payments. Given the program benefits and dollars involved, we urged CMS to look for an opportunity to identify erroneous federal eligibility determinations and implement corrective actions as soon as possible.
- With regard to our second recommendation—to use the information obtained from state and federal eligibility reviews to inform the agency's review of expenditures for different eligibility groups in order to ensure that expenditures are reported correctly and matched appropriately—HHS agreed with the concept of our recommendation, but noted that eligibility and expenditure reviews are two distinct, but complementary oversight processes, with different timeframes. We continue to believe that using the information obtained from state and federal eligibility review to inform the agency's review of expenditures for different eligibility groups will help ensure that expenditures are reported correctly and matched appropriately.

We also recommended that CMS take three actions to better minimize the risk of coverage gaps and duplicate coverage for individuals transitioning between Medicaid and the exchange in FFE states.

- With regard to our first recommendation—monitoring the timeliness of account transfers from state Medicaid programs to CMS and identifying alternative procedures as necessary—HHS commented in September 2015 that HHS monitors and reviews account transfers on a weekly basis and resolves any concerns about transfer frequency with the states. However, we do not believe these actions are

sufficient to address the recommendation, as knowing the frequency of account transfers may not provide enough information without HHS also having information on the timeliness of transfers—that is, the amount of time it takes the state to transfer an individual's account to CMS after determining that the individual is no longer eligible for Medicaid.

- With regard to our two other recommendations—including establishing a schedule for regular checks for duplicate coverage and developing a plan to routinely monitor the effectiveness of the checks and other planned procedures to prevent and detect duplicate coverage—HHS stated in September 2015 that its first check was underway in August 2015. HHS said that it will analyze the rate of duplicate coverage identified and gather input from states on the level of effort needed to conduct the check in order to establish the frequency of future checks. HHS also stated that it will monitor the rate of duplicate coverage identified in its checks and that it is working to implement additional internal controls to reduce duplicate coverage. We believe that these actions could be sufficient to address the recommendations—depending on how frequently the checks are performed and whether CMS's plan for monitoring the results of the checks incorporates target levels of duplicate coverage the agency deems acceptable. The less frequently the checks are conducted, the longer duplicate coverage could last, and without such targets, it will be difficult for CMS to provide reasonable assurance that its procedures are sufficient or whether additional steps are needed.

3. Some may argue that any duplicate payments will be resolved through the tax reconciliation process because individuals that receive a subsidy are required to file income tax returns. To what extent has the tax reconciliation process helped to address duplicate federal payments resulting from dual coverage? For example, how would the tax reconciliation process interact with enrollees who do not file taxes?

The IRS's process for reconciling the amount of the APTC individuals may owe has the potential to reduce the financial implications of any duplicate federal payments, but challenges exist. Although we have not assessed the extent to which this process helped to address any duplicate payments resulting from duplicate coverage in tax year 2014, we reported in October that, according to IRS officials, IRS will generally not have the information necessary to identify duplicate coverage until the tax filing season for tax year 2015, when states are required to report Medicaid enrollment data to IRS. Further, once IRS begins receiving the data, its ability to identify the need for repayment due to duplicate coverage will depend on the quality of the data and IRS's available resources. For example, we reported in July 2015 that the IRS experienced challenges related to the APTC reconciliation process for tax year 2014, including that incomplete and delayed data from the exchanges limited IRS's ability to match taxpayer claims for the APTC with exchange data at the time of return filing.¹ Among other recommendations, we recommended that IRS assess whether exchange data delays are an ongoing problem, assess the reliability of the data for IRS matching, and work with CMS to get complete data.

¹See GAO, *Patient Protection and Affordable Care Act: IRS Needs to Strengthen Oversight of Tax Provisions for Individuals*, GAO-15-540 (Washington, D.C.: July 29, 2015).

4. In your testimony, you mentioned some actions CMS was taking to identify consumers who are dually enrolled in Medicaid and marketplace coverage. The Congressional Budget Office has estimated that Exchange subsidies and related spending—as well as the increased Medicaid and CHIP outlays under the law—cost federal taxpayers \$77 billion in 2015. Next year, CBO notes the total cost for Exchange and Medicaid related spending due to the law will jump to \$116 billion dollars. Given the financial implications of duplicate coverage for both the beneficiary and the American taxpayers, what is CMS doing to prevent such duplication from occurring in the first place?

We reported that CMS has a number of policies and procedures that may help prevent duplicate coverage in FFE states. For example, when individuals in FFE states are determined potentially eligible for subsidized exchange coverage, CMS conducts automated checks of state IT systems to determine if individuals already have Medicaid coverage.² In addition to these checks, CMS has guidance on the FFE website that outlines the steps individuals must take when they have subsidized exchange coverage and are later determined eligible for Medicaid, including that they are responsible for ending subsidized exchange coverage. CMS also notifies individuals in FFE states of this responsibility when they are enrolling in exchange coverage as well as when they are determined eligible or potentially eligible for Medicaid. However, we also reported weaknesses in CMS's controls to prevent duplicate coverage, including limitations in CMS's check for Medicaid coverage in FFE states, and that CMS does not have procedures to automatically terminate exchange subsidies when individuals are determined eligible for Medicaid. Because CMS's planned steps to address the risk of duplicate coverage in FFE states focus on steps to identify and resolve rather than prevent duplicate coverage, we recommended that CMS develop a plan to monitor the effectiveness of procedures to prevent and detect duplicate coverage and take additional actions as appropriate.

5. Your report seems to indicate that CMS has been changing the guidance and parameters of the pilot eligibility reviews. What implications does changing the instructions midstream have for the usefulness of the results?

We reported that states had completed the initial round of pilot eligibility reviews, which showed wide variation in both the design and the results among the states—reflecting, in part, the latitude they were given in designing their review methodology. For subsequent rounds, CMS revised its guidance to standardize state reporting of results. For example, CMS updated instructions for the second round to include standard definitions for errors and deficiencies, and to require the inclusion of eligibility redeterminations in the review, and plans to further refine the instructions for future rounds. Based on these updated instructions, the results of the future rounds of pilot eligibility reviews may result in more comparable information across states.

²For this check to work, states' Medicaid IT systems must respond to electronic inquiries from the FFE on applicants' current Medicaid coverage. According to CMS officials, six states—Alaska, Kansas, New Jersey, Tennessee, Oregon, and Wyoming—were unable to perform this check as of July 2015. This check supplements the question in the application asking the applicant to attest to whether they have minimum essential coverage, including Medicaid.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (2021) 225-2927
Minority (2021) 225-3641

November 19, 2015

Mr. Seto Bagdoyan
Director
Audit Services
Forensic and Investigative Service
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Bagdoyan:

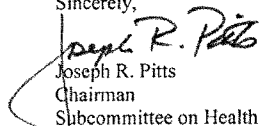
Thank you for appearing before the Subcommittee on Health on October 23, 2015, to testify at the hearing entitled "Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on December 3, 2015. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment



U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

December 17, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

On October 23, 2015, the Subcommittee on Health held a hearing entitled, "Reviewing the Accuracy of Medicaid and Exchange Eligibility Determinations." The attachment contains GAO's responses to the Questions for the Record received following our testimony at this hearing. The responses are based primarily on GAO's work done for the testimony and also work presented in previously issued GAO reports. If you have any questions regarding these responses, please contact me at (202) 512-6722 or BagdoyanS@gao.gov.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Seto J. Bagdoyan", followed by a long horizontal flourish.

Seto J. Bagdoyan
Director of Audits
Forensic Audits and Investigative Service

Enclosure

HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
QUESTIONS FOR THE RECORD

HEARING:
"REVIEWING THE ACCURACY OF MEDICAID AND EXCHANGE ELIGIBILITY DETERMINATIONS"
FRIDAY, OCTOBER 23, 2015

From Mr. Pitts

1. **Individuals who are eligible for Medicaid are not eligible to receive subsidized coverage through an exchange. For the cases in which you applied for Medicaid coverage and ultimately ended up obtaining subsidized exchange coverage, how did the exchange verify that the applicant had been denied Medicaid coverage?**

GAO Response: As described in GAO's October 23, 2015, testimony, officials from the Centers for Medicare & Medicaid Services (CMS) told GAO the federal Health Insurance Marketplace (Marketplace) does not require proof of a Medicaid denial when processing qualified health-plan applications, nor does the Marketplace verify such a denial with the respective state. CMS officials said that instead, they accept the applicant's attestation that the applicant was denied Medicaid coverage.

As described below in the GAO Response to Question 2, these results occurred in the specific situation of states that had delegated their Medicaid eligibility determinations to the federal Marketplace. Generally, both state and federal marketplaces are intended to operate on a "no wrong door" basis, providing a single point of application for private health plans, Medicaid, or the Children's Health Insurance Program. This practice is intended so that an individual can receive an eligibility determination using the same application, without the need to submit information to multiple programs.

2. **In your statement you indicate that 4 of the 8 applicants who applied for Medicaid coverage were not enrolled in Medicaid but were able to obtain subsidized exchange coverage. While this could be seen as a positive sign that Medicaid eligibility determinations are working well, in reality it sounds like at least some of the applicants were unable to get Medicaid coverage—not because they were deemed ineligible—but because of system issues in transferring information between the federal exchange and state Medicaid programs. Is that correct? If so, can you please explain the problems that were encountered?**

GAO Response: Three of the four cases in which GAO obtained subsidized qualified health-plan coverage in lieu of Medicaid took place in two states—New Jersey and North Dakota—that had delegated their Medicaid eligibility determinations to the federal Marketplace at the time of the GAO undercover investigation. It was for these three applications that transfer of information from the federal Marketplace to the respective state was at issue.¹ Specifically:

¹The fourth case in which GAO obtained subsidized qualified health-plan coverage in lieu of Medicaid was Kentucky, which at the time of the GAO undercover investigation operated its own exchange. Thus, transfer of information from the federal Marketplace to the state was not at issue.

- For two undercover applications for New Jersey Medicaid coverage, the federal Marketplace told GAO's undercover applicants they would be contacted by the state Medicaid office within 30 days. However, the New Jersey Medicaid office did not notify the GAO undercover applicants within 30 days. GAO undercover staff periodically called the state Medicaid office over the course of approximately 4 months, attempting to determine the status of the undercover GAO applications. In these calls, New Jersey representatives indicated they had not yet received Medicaid information from the federal Marketplace and, on several occasions, said they expected to receive it shortly. Because GAO's undercover applicants could not obtain resolution with the state Medicaid office, the undercover applicants subsequently contacted the federal Marketplace to obtain subsidized coverage.

CMS officials told GAO that New Jersey had a system issue that may have accounted for problems in the undercover GAO Medicaid application information being sent to the state. The CMS officials also said that the system issue was subsequently resolved. However, New Jersey officials declined GAO's request for a meeting to discuss the results of the GAO undercover investigation. Therefore, GAO could not draw a conclusion on the nature of any system issue New Jersey experienced.

- For one application for North Dakota Medicaid coverage, the federal Marketplace told the undercover GAO applicant that the applicant would be contacted by the state Medicaid office within 30 days. However, the North Dakota Medicaid office did not notify the GAO undercover applicant within 30 days. GAO's undercover staff called the North Dakota Medicaid agency to determine the status of the undercover application. An agency representative told GAO staff that the federal Marketplace denied the undercover GAO Medicaid application and therefore did not forward the Medicaid application file to North Dakota for a Medicaid eligibility determination. However, the GAO undercover applicant did not receive notification of denial from the federal Marketplace.

3. In requesting the identities of GAO's fictitious applicants, CMS is claiming that the agency needs this information to address the control gaps that GAO has identified. Therefore, please respond to the following questions.

- a. GAO has conducted undercover work, including the use of fictitious applicants, to test controls in other programs aside from the ACA. Is that correct?**

GAO Response: Yes, GAO has conducted undercover work, including the use of fictitious applicants, to test controls in other federal programs in addition to health-care coverage provided under the Patient Protection and Affordable Care Act (PPACA). GAO has received requests for undercover work from both chairs or ranking members of a number of congressional committees and subcommittees.

Examples of such work include:

- *Paid Tax Return Preparers: In a Limited Study, Preparers Made Significant Errors*, GAO-14-467T, April 8, 2014.

- *Head Start: Undercover Testing Finds Fraud and Abuse at Selected Head Start Centers*, GAO-10-1049, September 28, 2010.
- *Small Business Administration: Undercover Tests Show HUBZone Program Remains Vulnerable to Fraud and Abuse*, GAO-10-759, June 25, 2010.
- *Low-Income Home Energy Assistance Program: Greater Fraud Prevention Controls Are Needed*, GAO-10-621, June 18, 2010.

b. Has GAO ever provided these other agencies with identifiable information about its undercover work?

GAO Response: Yes, for certain engagements in the past, where appropriate, GAO has provided certain identifiable information to agencies about its undercover work, in order to provide agency management with information to improve operations or identify waste, fraud, or abuse. However, in certain circumstances, GAO cannot disclose certain identifiable information if it may affect GAO's ability to conduct further work in that area using that identification.

c. Have other agencies been able to correct issues that GAO identified through its undercover work without having identifiable information?

GAO Response: GAO's general practice is to conduct briefings for officials at the tested entity before issuing any final report, in order to inform the officials that their agency or program has been the subject of an undercover investigation; to share the results of the investigation; and to discuss potential remedies for any identified control weaknesses or security vulnerabilities. For example, for GAO's undercover work on health-care applications under PPACA, GAO conducted a briefing with CMS officials to inform them of GAO investigative findings and related issues, in advance of the October 2015 hearing. (See additional detail in part (d) following.) GAO did this without disclosing the specifics of its undercover identities.

Similarly, GAO briefed officials at state marketplaces in Kentucky and California on its investigative results, and officials there said they were taking corrective action based on the GAO results.

d. What information has GAO shared with CMS about the fictitious applications?

GAO Response: After concluding its undercover investigation, GAO briefed officials from CMS on the results of the work, but without, as noted above, providing identifiable information. Specifically, GAO provided highly detailed information to CMS on the undercover applications, as follows:

- In August 2015, GAO provided details of each applicant scenario discussed in the October 2015 testimony. For each undercover applicant, we described the series of interactions with the respective marketplace, contractor, and/or state Medicaid agency. This included a description of each interaction, including whether by Internet, phone, fax, or mail; the type of information requested and provided for each interaction; and whether the identity was rejected, allowed to proceed, or to enroll.

- In August 2015, GAO met with CMS officials to discuss the undercover results, including the material described above.
- Prior to the October 2015 hearing, GAO provided CMS with a summary of facts to be included in the hearing statement.

In addition, as part of earlier but related work, GAO delivered a July 2015 testimony that reported detailed results of undercover testing for the 2014 coverage year.² GAO plans to issue a final public report on this related work in February 2016, to include a number of recommendations that should enable CMS to strengthen the enrollment and verification processes.³

e. How can CMS use the information GAO provided to address the gaps identified by GAO's work?

GAO Response: GAO believes the information provided to CMS and the state marketplaces is sufficient for them to be able to identify vulnerabilities that allowed GAO's undercover applicants to be enrolled, and to take appropriate corrective measures. As noted above, GAO provided information on its undercover activities to the state marketplaces, and state officials outlined to GAO staff steps they plan to take to modify their eligibility determination processes, and related training for their staffs, after learning the results of the GAO testing. In addition, as also noted above, GAO plans to issue a final public report based on related work, with a number of recommendations to CMS.

4. What did you find the key differences to be between the state and federal marketplaces? Have the state-based exchanges done a better job than the federal exchange in ensuring that the necessary controls are in place?

GAO Response: Although GAO's investigation included the federal Marketplace and two state marketplaces, the undercover results are illustrative and cannot be generalized to the full population of enrollees. Therefore, GAO cannot draw conclusions about any key differences between the state and federal marketplaces. However, as noted above, the two state marketplaces where GAO conducted undercover work—Kentucky and California—have told GAO they are taking corrective action after learning the results of the GAO testing.

5. Some have suggested GAO should not be testifying on preliminary results. Has GAO testified or presented preliminary results for other issues in the past?

GAO Response: Yes, GAO has testified on preliminary results for other issues in the past. It is important for GAO to be able to testify before issuance of a report when our findings are sufficiently developed. GAO does this with some frequency to support oversight and legislative efforts. In particular, we have done so on at least eight occasions for fiscal year

²GAO, *Patient Protection and Affordable Care Act: Observations on 18 Undercover Tests of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided under the Act*, GAO-15-702T (Washington, D.C.: July 16, 2015).

³In particular, this examination focuses on the enrollment process for the federal Marketplace, including an assessment of how application information is verified. GAO has met with CMS staff to review findings planned to be in that report, including discussion of preliminary recommendations.

2015, on a variety of topics, including critical infrastructure, disability insurance, counterterrorism, rural housing, the federal workforce, and Indian affairs.

a. Can you provide a couple of examples?

GAO Response: Recent examples of such testimony include:

- *Veteran-Owned Small Businesses: Preliminary Observations on Verification Program Progress and Challenges*, GAO-16-179T, November 4, 2015.
- *High-Containment Laboratories: Preliminary Observations on Federal Efforts to Address Weaknesses Exposed by Recent Safety Lapses*, GAO-15-792T, July 28, 2015.
- *Critical Infrastructure Protection: Preliminary Observations on DHS Efforts to Address Electromagnetic Threats to the Electric Grid*, GAO-15-692T, July 22, 2015.

b. Between now and when you issue your final report will your key findings that you were able to obtain coverage for 17 of 18 applicants change?

GAO Response: GAO does not anticipate that its key findings, presented as preliminary results in GAO's October 2015 testimony, will change. This is because undercover investigative work on which the results were based is complete.

6. What modes (e.g. online, paper applications, telephone) did the fictitious applicants use to apply for coverage? Given that all but one applicant obtained coverage, what does this imply about the enrollment controls and vulnerabilities that exist for the various modes available for obtaining coverage?

GAO Response: At the outset, 10 of 18 GAO undercover applicants applied by phone, and 8 applied online. As GAO reported in its October 2015 testimony, for 14 applications, we failed during the initial portion of the undercover work to clear an identity-checking step. As a result, we were directed to contact a contractor that handles identity checking.⁴ As described in GAO's testimony, GAO ultimately obtained coverage for 17 of 18 undercover applicants.

GAO's undercover investigation as a whole found that the health-care marketplace eligibility determination and enrollment process remains vulnerable to fraud. However, as GAO noted in its testimony, the results, while illustrative, cannot be generalized to the full population of enrollees.

⁴Known as "identity proofing," the process uses personal and financial history on file with a credit-reporting agency. The marketplace generates questions that only the applicant is believed likely to know. According to CMS, the purpose of identity proofing is to prevent someone from creating an account and applying for health coverage based on someone else's identity and without their knowledge. Although intended to counter such identity theft involving others, identity proofing thus also serves as an enrollment control.